Supreme Court, U.S.
FILED

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No.

IN THE

Supreme Court of the United States

JOHN R. CONNOR, Executor of
The Estate of Helen T. Hanlon, Deceased,

Petitioner,

-v-

TOMMY G. THOMPSON, Secretary of the
Department of Health and Human Services,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE THIRD CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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Helen T. Hanlon,
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QUESTIONS PRESENTED FOR REVIEW

1. Whether 42 CAR §405.817(a)(1), the Social Security Administration's regulation which defines the "amount in controversy" for purposes of an appeal to an Administrative Law Judge, which regulation is formulated for the purpose of establishing Medicare's remaining potential liability on a benefits claim, can be applied to a beneficiary who is arguing that there is *no* liability *per se* on the claim, either on the part of Medicare or the beneficiary, without violating Due Process and Equal Protection guarantees in the United States Constitution?

2. Whether 42 U.S.C. §405(h)'s prohibition of 28 U.S.C. §1331 (federal question) actions can be applied to a beneficiary who is *not* seeking to recover a monetary benefit from Medicare; and, alternatively, whether jurisdiction can be otherwise asserted herein under 28 U.S.C. §1331, 42 U.S.C. §405(g) or 42 U.S.C. §1395ff(b)(2)(B)?

LIST OF ALL PARTIES

The parties to the proceedings below were:

1. John R. Connor, Executor of the Estate of Helen T. Hanlon, Deceased – plaintiff-petitioner.

2. Tommy G. Thompson, Secretary of the Department of Health and Human Services – defendant-respondent.

3. Jo Anne B. Barnhart, Commissioner of the Social Security Administration – defendant (dismissed in accordance with district court's Order dated December 11, 2003). (App. G, *infra*, p. 29a)

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OPINIONS BELOW

Petitioner seeks review, on his petition for writ of certiorari to the United States Court of Appeals for the Third Circuit, of an adverse Opinion and Judgment rendered by the Third Circuit on October 14, 2004, affirming the Opinion and Order issued by the District Court of New Jersey granting respondent's Rule 12(b)(1) motion for dismissal on October 16, 2003. The Opinion and Judgment rendered by the Third Circuit Court of Appeals is unreported and is set out in full at Appendix A, pages 1-7a, and Appendix B, pages 8-9a. The Opinion and Order of Dismissal issued by the District Court of New Jersey is unreported and is set out in full at Appendix C, pages 10-19a, and Appendix D, pages 20-21a.

JURISDICTION

The judgment of the Court of Appeals for the Third Circuit was entered on October 14, 2004. A timely petition for rehearing was denied on December 16, 2004. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1). The jurisdiction of the District Court was invoked under 42 U.S.C. § 405(g) and 20 CFR §404.981.

CONSTITUTIONAL PROVISIONS, STATUTES, REGULATIONS AND COURT RULES INVOLVED

The Fifth Amendment to the United States Constitution provides in pertinent part:

> No person shall be * * * deprived of life, liberty, or property without due process of law. . .

42 *U.S.C.* §1395ff(b)(2)(B) (2001) provides in pertinent part:

> [U]nder part B of this subchapter, a hearing shall not be available to an individual under paragraph (1)(C) and (1)(D) if the amount in controversy is less than $500 (or $100 in the case of home health services) and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than $1,000.[1]

42 *U.S.C.* §1395y(a)(1)(A) states in pertinent part:

> Notwithstanding any other provision of this subchapter, no payment may be made under Part A or Part B of this subchapter for any expenses incurred for items or services * * * which * * * are not reasonable and necessary for the diagnosis or treatment of illness or injury. . .

42 *U.S.C.* §405(g) provides in pertinent part:

> Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision . . .

42 *U.S.C.* §405(h) provides in pertinent part:

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[1] Amended Dec. 21, 2000 and made applicable to initial determinations made on or after October 1, 2002, the hearing requirement is reduced from $500 to $100. (Initial Determination, *infra*, is dated July 31, 2001). 42 U.S.C. § 1395ff(b)(1)(E)(1).

> The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 *CFR* §405.815 states in pertinent part:

> Any party designated in Sec. 405.822 is entitled to a carrier hearing after a review determination has been made by the carrier if the amount in controversy is $100 or more * * * To be entitled to a hearing before an ALJ following the carrier hearing, the amount remaining in controversy must be $500 or more, and for judicial review following the ALJ hearing and Departmental Appeals Board Review, the amount remaining in controversy must be $1000 or more.

42 *CFR* §405.817(a)(1) states in pertinent part:

> (a) Individual appellants. For the purpose of determining whether an individual appellant meets the minimum amount in controversy needed for a carrier hearing ($100) or ALJ hearing ($500), the following rules apply:

> (1) The amount in controversy is computed as the actual amount charged the individual for the items and services in question, less any amount for which payment has been made by the carrier and less any deductible and coinsurance amounts in the particular case.

STATEMENT OF THE CASE

The within petition for a writ of certiorari is predicated upon petitioner's Due Process and Equal Protection challenge to a regulation of the Social Security Administration, to wit: 42 CFR §405.817(a)(1), which defines "amount in controversy" for the purpose of a Part B appeal to an Administrative Law Judge.

Petitioner estate contends that the regulation, as written and applied *infra* by the agency is barring the estate from an agency hearing before an Administrative Law Judge on its claim that it owes nothing on a bill, submitted to Medicare, by one of decedent's former physicians. Under the circumstances, the estate will be liable for the bills of no less than two primary care physicians rendered at the same time for the same patient, decedent Helen T. Hanlon.

A. Factual and Procedural Background

Petitioner is the executor of the Estate of Helen T. Hanlon (deceased April 7, 2000). Since March 1, 1996, petitioner had served as Health Care Representative for Helen Hanlon, his cousin. The Proxy Directive granted petitioner, in the event of his cousin's disability, the right to make health care decisions and the authority to "hire and *discharge* physicians to care for [decedent]." (App. C at 11a). (Emphasis added).

Four years later, on March 9, 2000, Helen Hanlon (hereafter referred to as "decedent") was admitted to Overlook Hospital in Summit, New Jersey with symptoms of cardiac insufficiency and remained in the hospital's Intensive Care Unit ("ICU") until her death on April 7, 2000. Id. On or about March 17, 2000, decedent, suffered a Coumadin (blood thinner) bleed in her lower left quadrant, which adversely impaired her kidney function. She became comatose and remained so until her death. Id.

At this time, decedent was under the care of her primary care physician, Susan B. Profeta, M.D., who, following the Coumadin bleed incident, suggested to petitioner that a nephrologist (kidney specialist) be brought in to attempt to medically restart decedent's kidney function. Petitioner agreed to the suggestion and, acting on Dr. Profeta's suggestion, retained Dr. Burton Tucker, M.D. (Medical Diagnostic Associates, P. A.) for that purpose.

After the March 17, 2000 coumadin bleed, Dr. Susan Profeta, on several occasions, asked petitioner to sign a Do Not Resuscitate ("DNR") Order for decedent, which request petitioner consistently declined. A problem with decedent's treatment that occurred on March 27, 2000 involving an attempt to feed decedent via a feeding tube, which procedure had not been discussed with plaintiff beforehand, gave petitioner the impression that Dr. Profeta intended to proceed with decedent's care without consulting petitioner. Shortly thereafter, when petitioner was advised by a hospital staff member that decedent's doctors were planning to perform a bronchoscopy of decedent's lungs, of which procedure petitioner knew nothing, he contacted decedent's attorney who, at his request, on March 28, 2000, sent a letter to Dr. Profeta advising her that petitioner's "consent must be secured *prior* to the performance of any invasive procedures. (App. M at 52a). (Emphasis added).

Immediately thereafter, on March 30, 2000, Dr. Profeta telephoned petitioner to inform him that she was resigning from the case and to get another primary care physician. (App. M at 52a). Petitioner immediately replaced Dr. Profeta as primary care physician with the nephrologist, Burton Tucker, M.D., who accepted the assignment. The following morning, on March 31, 2000, Dr. Profeta encountered petitioner at the hospital and advised that she had had a change of mind and requested to come back on the case. The offer was declined by petitioner who advised Dr. Profeta that Dr. Tucker had "stepped up" to serve as decedent's primary care physician. Id. at 53-54a.

Dr. Tucker's status as decedent's primary care (attending) physician was expressly confirmed in writing on March 31, 2000, when petitioner executed a DNR Order and designated Dr. Burton Tucker as decedent's attending physician. (App N, at 59-60 a). The Order, placed on decedent's chart in I.C.U., ruled out aggressive therapy (chest compressions, shock, etc.) in the event of heart failure. The Order was countersigned by a hospital physician in the I. C. U. unit (Dr. E. Nguyen), and subsequently by Dr. Tucker, himself. Id. The Order was omitted from the copy of decedent's medical records turned over to petitioner and was not given to petitioner until the second Medicare Fair Hearing had concluded the following year on September 20, 2001.

The following month, after decedent's passing, petitioner received an Explanation of Medicare Part B Benefits Statement, dated May 5, 2000, whereon it was shown that Dr. Profeta had submitted to Medicare, and received payment for, eight (8) visits she allegedly made to decedent during the March 30 – April 7, 2000 period, after she had resigned and been replaced by another physician as primary care for decedent. (App. C at 11a). Dr. Profeta later claimed, during the Medicare Fair Hearings' phase of this case, that she could never get in touch with Dr. Tucker to confirm his status as decedent's primary care physician and so,

without petitioner's knowledge or permission, simply remained on the case. (App. M at 54a). (The Medicare billing records of both physicians evidence that both Dr. Profeta and Dr. Tucker had actually attended decedent on the same days of March 30 and March 31, 2000). From March 18, 2000 to April 5, 2000, Dr. Tucker (Medical Diagnostic Associates, P.A.) and his associates attended decedent, billing a total of $1,608.33 to Medicare, which award Petitioner did not contest. However, petitioner did appeal to Medicare Fair Hearings the award of the Medicare carrier (Empire Medical Services) to Dr. Profeta, who had billed Medicare for $640.00 for 8 visits (@ $80.00 per visit, which claim was allowed at .80%, or $487.52, leaving an amount of $121.98 as the estate's obligation, which figure became the "amount in controversy" figure for the next level of appeal to an Administrative Law Judge ("ALJ"). 42 CFR §405.817(a)(1). (App. L at 48a).

The Medicare Fair Hearing ("MFH") on petitioner's appeal of the award to Dr. Profeta took place on July 30, 2001 at 10 a.m. -- at a time when petitioner was midway between Ireland and Newark, New Jersey, returning from a two-week trip to Europe. (App. M at 51-52a). Petitioner had no prior knowledge of the (telephone) hearing. Only one employee (Pilar Kerr) from the billing department of Dr. Profeta's Paramount Medical Group attended. (App. L at 43a). There was no appearance for the estate. Id. Plaintiff forthwith filed a motion for reconsideration with Medicare Fair Hearings, which, in its Initial Decision, had found that "Dr. Susan Profeta was the primary care physician and [that] the documentation supports the billing of the eight subsequent hospital visits in question." (App. L at 47a). Additionally, that the "official transfer of the primary care of the patient [from Profeta to Tucker] never occurred." Id. at 46a.

On September 20, 2001, at 9:00 a.m., Medicare Fair Hearings conducted a telephone "reopening" hearing on

petitioner's reconsideration motion. After the hearing had concluded, there arrived in the mail that afternoon, from Overlook Hospital, a copy of the March 31, 2000 DNR Order (App. N at 59a) appointing the replacement physician (Tucker) that had not originally been turned over to plaintiff when decedent's medical records, totaling 367 pages, were forwarded by the hospital, and which order petitioner had been trying to obtain for the second hearing. The order was received too late to use during the second hearing and does not figure in the second Fair Hearing decision, which denied petitioner's motion for reconsideration. (App. M at 50-58a).

Petitioner appealed both Medicare Fair Hearings decisions (the initial decision and the denial of the motion for reconsideration) to an Administrative Law Judge, who dismissed the appeal for lack of jurisdiction because the "amount in controversy," as computed under 42 CFR §405.817(a)(1) was less than the $500.00 required for an ALJ hearing under 42 CFR §405.815. (App. H at 30-32a). A subsequent appeal to the Medicare Appeals Council was denied for the identical reason on August 16, 2002, which order became the final order of the agency. (App. I at 33a). On October 21, 2002, petitioner filed the complaint in this action in the United States District Court for the District of New Jersey, for review of the agency's August 16, 2002 decision.

Despite the August 16, 2002 Medicare Appeals Council decision barring an ALJ hearing in this matter (App. I at 33a) an ALJ (Dean W. Determan) scheduled and conducted a hearing in Newark, New Jersey on September 17, 2002. On that date, a merits hearing was held wherein testimony was taken, including that of petitioner, the aforesaid Pilar Kerr, and an agency medical expert, Max Yablonsky, M.D. Exhibits were introduced into the record, including the aforementioned DNR

Order.[2] On October 21, 2002, the ALJ declined to issue a decision on the merits, deciding he did not possess jurisdiction in the appeal because the amount in controversy, as calculated by §405.817(a)(1), was less than $500.00. (App. J at 35-39a).

On April 23, 2003, respondent filed a motion in the District Court to dismiss the complaint in this action under FRCP 12(b)(1) for lack of subject matter jurisdiction, specifically arguing that the district court did not possess jurisdiction inasmuch as petitioner did not meet the $1,000.00 "amount in controversy" figure required for judicial review under 42 U.S.C. §1395ff(b)(2)(B). Petitioner opposed dismissal on the ground that the $1,000 minimum did not apply under the circumstance where there was a challenge to the constitutionality of an agency regulation, in this case 42 CFR §405.817(a)(1), which regulation petitioner had challenged on due process grounds before the agency. No oral argument was held on the dismissal motion in the district court.

On October 15, 2003, the district court (Cavanaugh, J.) issued an Opinion and Order granting respondent's motion to dismiss on the grounds that Plaintiff did not satisfy the $1,000.00 minimum for judicial review and, additionally, that "no constitutional claim in fact exists. . . and [that] there is an available forum in [the] New Jersey Superior Court to adjudicate [petitioner's] claims." (App. C at 19a). The court, however, erroneously dismissed petitioner's complaint under FRCP 21, instead of FRCP 12(b)(1). (App. D at 20a).

Petitioner timely filed a Motion to Alter or Amend Judgment, under FRCP 59(e), to change the dismissal from FRCP 21 to FRCP 12(b)(1). Although petitioner specifically

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[2] Petitioner's request for a formal hearing, including testimony under oath, and compulsory attendance for Doctors Profeta and Tucker, was not granted by ALJ Determan.

advised the court in his moving papers that he was not attempting to relitigate or reargue the merits of the case, the district court (Cavanaugh, J.), in a 4-page Opinion, denied what it deemed to be a "motion for reconsideration." (App. F at 24-27a).

Notwithstanding the court's decision, the accompanying Order *granted* petitioner the relief he had requested: 1) a dismissal under FRCP 12(b)(1) and 2) the dismissal of Defendant Commissioner of the Social Security Administration from this case. (App. G at 28-29a).

* * * * * *

Petitioner, as executor of the Estate of Helen T. Hanlon challenged an initial award by the Medicare carrier (Empire Medical Services) to one of decedent's former physicians (Susan Profeta, M. D.), and attempted, unsuccessfully, to appeal that adverse determination to an Administrative Law Judge ("ALJ"). The criteria for determining eligibility for an ALJ hearing is predicated upon the "amount in controversy":

> "To be entitled to a hearing before an ALJ following the carrier hearing, the amount in controversy must be $500 or more, and for judicial review following the ALJ hearing and Departmental Appeals Board Review, the amount remaining in controversy must be $1000 or more."

42 CFR §405.815. Petitioner is not challenging this regulation *per se*, but argues that he meets the $500 requirement because he is challenging the physician's $640.00 bill *in its entirety*. The regulation petitioner is challenging, 42 CFR §405.817(a)(1), defines the formula for computing the amount in controversy accordingly:

> "The amount in controversy is computed as the actual amount charged the individual for the items and services in question, less any amount for which payment has been made by the carrier and less any deductible and coinsurance amounts applicable in the particular case."

Id. As applied in the agency's March 12, 2002 Order of Dismissal the amount in controversy is only $121.98 (App. H at 30-32a).

Plaintiff, however, since the inception of this case, has been contesting the fact that any Medicare monies were paid to Dr. Profeta for the March 30 – April 7, 2000 period in question because this physician had resigned from decedent's case on March 30, 2000 and been replaced by another physician. (App. M at 56a).

Although the Medicare decisions in this case have been adverse to petitioner on this issue, the Hearing Officer at the Medicare Fair Hearings, in her September 25, 2001 decision, allowed that petitioner might well be entitled to an ALJ hearing, when she stated:

> However, I would like to mention that Mr. Connor indicated in his testimony that he felt that he should be entitled to a hearing before an Administrative Law Judge if my decision was to not revise the original hearing decision. He stated that since he was disputing the $640.00 charge and the fact that any Medicare payment was issued, the next level of appeal for him should be based on the billed charge of $640.00.

> I feel that Mr. Connor made an excellent point in computing the amount in controversy for the next level of appeal based on the fact that he was disputing that any Medicare reimbursement was made to Dr. Profeta. Therefore, I am providing Mr. Connor with the information for filing an appeal before an administrative law judge (ALJ). I cannot guarantee that an ALJ will accept the case; only the ALJ has the authority to make that decision.

(App. M at 56-57a). (Emphasis in original).

The narrow scope of 42 CFR §405.817(a)(1) is further highlighted in the October 21, 2002 decision of ALJ Determan who, in discussing the limitations of the "amount in controversy" formula, stated:

> "[t]he formula does not contemplate situations in which a party contends the amount previously approved is too high. It only considers how much has been billed on the claim, how much Medicare has allowed on the claim and how much more Medicare could potentially pay on the claim."

(App. J at 37a). (Emphasis added). These statements by Hearing Officer Canfield (Medicare Fair Hearings) and ALJ Determan evidence the total inadequacy of 42 CFR §405.817(a)(1) to allow for the situation, infra, where a beneficiary is challenging a physician's bill in its entirety and is arguing for either lower approved amounts or, as in this case, no approved amounts at all.

B. The District Court's Opinion

In its October 16, 2003 Opinion and Order (App. C & D at 10-21a), as amended by its Order of December 11, 2003 (App. G at 28-29a), the District Court dismissed the complaint in this action, under FRCP 12(b)(1) (lack of subject matter jurisdiction), not only because petitioner did not meet the $1,000 minimum for judicial review under 42 U.S.C. §1395ff(b)(2)(B) but also because, according to the court, plaintiff was *only* raising a constitutional issue in order to secure judicial review:

> "A plaintiff who fails to satisfy the $1,000 minimum cannot *then* claim that his rights have been violated in order to secure proper subject matter jurisdiction when *no constitutional claim in fact exists.*"

(App. C at 19a). (Emphasis added). The District Court thereby ignored the fact that petitioner has, in fact, been alleging the unfairness of the agency's application of §405.817(a)(1) to this case ever since the second MFH hearing back in September, 2001.

The District Court's 11-page Opinion dealt only in a broad sense with the due process issue, before its conclusory finding that "no constitutional claim in fact exists." Id. There was *no* discussion of how the regulation was adversely impacting the estate's claim to an ALJ hearing -- in fact, the District Court never even *once* mentioned 42 CFR §405.817(a)(1) in its Opinion and the regulation has been at the epicenter of this case before the agency, as its numerous opinions and orders amply attest.

In petitioner's complaint, jurisdiction was asserted under 42 USC §1395ff(b)(2)(B), wherein petitioner, in his opposition papers, claimed he was entitled to a waiver of the $1,000

minimum because he was challenging an agency rule on due process grounds, as well as 28 USC §1331 (federal question jurisdiction). Again, however, at no time in its Opinion did the district court even mention 28 U.S.C. §1331 as a basis for jurisdiction.

In its Opinion, the District Court attempted to distinguish the case herein from one cited by petitioner in his opposition brief, Bartlett v. Heckler, 576 F.Supp. 830 (D.C. Cir. 1983) wherein judicial review under §1331 was allowed for due process and equal protection challenges to a Medicare Act provision wherein the plaintiff's amount-in-controversy figure of $286.00 was well below the $1,000 jurisdictional minimum for judicial review "because plaintiff's claim is based on the constitution and because there is no alternative method of securing judicial review of her claim." Id. at 831. (Emphasis added).

In its Opinion, the District Court, which never mentioned either §405.817(a)(1) or §1331, attempted to distinguish the case *infra* from Bartlett, supra, by invoking the novel theory that "[p]laintiff is not alleging a violation of due process because he is seeking only a post-deprivation remedy for the $121.98 * * * [and] * * * the laws of the State of New Jersey provide avenues for such remedies." (App. C at 18a). (Emphasis added).

In support of its novel "post-deprivation" finding, the District Court creatively relied on an admiralty case (In Re Complaint of Bankers Trust Co., 752 F.2d 874 (3d Cir. 1984)) and two prisoner suits (Paratt v. Taylor, 451 U.S. 527 (1981) and Bonner v. Couglin, 517 F.2d 1311 (C.A. 7, 1975)), ignoring the fact that this "remedy" would pass jurisdiction on Medicare claims from federal to state courts, in violation of the legal fact that petitioner's sole remedy to secure judicial review of the Secretary's decision exists exclusively under federal Medicare statutes, rules and regulations. *See:* 42 U.S.C. §405(g)(h);

Abbey v. Sullivan, 978 F.2d 37 (2nd Cir. 1992). "Where the Medicare Act establishes procedures for review of the Secretary's decision, a court may not review that decision by any other means." Aquavella v. Richardson, 437 F.2d 397, 402 (2nd Cir. 1971). The District Court's boilerplate theory, challenged on appeal by petitioner before the Third Circuit, was neither defended by respondent nor mentioned by the Third Circuit in its Opinion.

C. The Court of Appeals' Opinion

In its Opinion, filed October 14, 2004, the Third Circuit Court of Appeals affirmed the dismissal of the within complaint in this action by the District Court.[3] (App. A at 1-7a). In that Opinion, the Third Circuit presented a flawed version of the facts in this case to the point where the factual predicate is almost unrecognizable.

First, while mentioning that "[o]n March 20 [2000] Dr. Profeta resigned from Hanlon's case," App. A at 2a, *no* mention was made by the appellate court that Profeta was immediately replaced by another doctor (Tucker) as decedent's primary care physician, whose name and important role in the factual predicate are never mentioned in the Opinion.[4] The picture thereby created is one of a doctor (Profeta) who, of her own volition, continued on a case after her resignation simply because there was no other primary care physician present. It buttressess the Third Circuit's citation to a finding in the first

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[3]The Third Circuit judgment affirmed the "judgment" of the District Court (App. B, at 9a), albeit the lower court entered only an Order of Dismissal (App. D at 20a).

[4] Dr. Burton Tucker, M.D. billed Medicare for 7 visits between March 30, 2000 and April 5, 2000 totalling $525.30, of which Medicare paid $420.75, which allowance petitioner did not contest. The Medicare allowance left a balance due of $104.55 as the estate's obligation.

Medicare Fair Hearing decision of July 31, 2000, that " '[s]ince the primary care of Helen Hanlon was never officially turned over to [another doctor], Dr. Profeta had a legal and moral obligation to continue treating and providing comfort measures for this patient until her death.' " (App. A at 2a).

Second, no mention was made by the Third Circuit in its Opinion that a second hearing had to be scheduled by Medicare Fair Hearings because the first one, on July 31, 2000, took place on the same day petitioner was returning from a trip in Europe. And it is in that second hearing decision that Hearing Officer Lorraine Canfield stated that petitioner had "made an excellent point computing the amount in controversy for the next level of appeal based on the fact that he was disputing that any Medicare reimbursement was made to Dr. Profeta." App. M at 57a. That significant statement was not mentioned by the Third Circuit, either.

Thirdly, the Third Circuit omitted any reference in its Opinion to the DNR Order which petitioner executed on March 31, 2000 (App. N at 59-60a), which Order was not produced by Overlook Hospital until it was too late to use in the second MFH hearing on September 20, 2001. This Order is probative of the fact that Dr. Profeta possessed no role, either legal or ethical, in decedent's care after her resignation on March 30, 2000. And although this critical piece of evidence could not be used during the second MFH hearing, it was introduced into the record at the merits hearing conducted by ALJ Dean W. Determan on September 17, 2002. (See: Statement of Facts, infra, at pp. 8-9). Unfortunately, the ALJ hearing that eventually took place in this case was never mentioned by the Third Circuit in its Opinion.

Fourth, the appellate court misrepresents petitioner's position in this case accordingly:

> He argues, however, that he is not subject to the $1000 amount in controversy requirement because his claim does not arise under the Medicare Act, but rather involves a constitutional challenge. Therefore, according to Connor, § 405(h) does not prevent the District Court from exercising § 1331 jurisdiction over his complaint.[5]

Id. at 4-5a. As asserted in petitioner's Third Amended Complaint in this action, federal jurisdiction was alleged not only under 28 U.S.C. §1331 but also under the Medicare Act, 42 U.S.C. §1395ff(b)(2)(B), which jurisdictional claim merited neither mention nor discussion by the Third Circuit.

Aside from the aforementioned factual errors, the Third Circuit's Opinion contains substantive errors of law. To support its proposition that petitioner was relying strictly on federal question jurisdiction, the Third Circuit relied on a series of "channeling" decisions, principally Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (2000), which barred §1331 jurisdiction on an original lawsuit challenging certain Medicare regulations. Quoting from Shalala, supra, the Third Circuit stated that "[i]n holding that federal question jurisdiction was barred under § 405(h), as incorporated by § 1395ii, the Court recognized that the 'bar did not preclude constitutional challenges,' but simply 'require[d] that they be brought' under the same 'jurisdictional grants' and 'in conformity with the same standards' applicable 'to nonconstitutional claims arising under the Act," App. A at 5a, which is to say that they had to be first

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[5] 42 U.S.C. §405(h) states that "[n]o action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." §405(h) is made applicable to the Medicare Act by 42 U.S.C. §1395ii.

presented to or"channeled" through the agency. The Third Circuit concluded that "Connor is required to 'channel' his claim through the review procedures and requirements of the Medicare Act." Id. at 6a. Of course, this is *precisely* what petitioner has been doing in this case since its inception - "channeling" his claim through the review procedures and requirements of the Medicare Act, in order to secure an ALJ hearing on the estate's claim. The agency, in its orders and opinions, has encountered no such problem in recognizing the estate's challenge to 42 CFR §405.817(a)(1).

Not to deny all possible relief to petitioner on his due process claim, the Third Circuit, relying on Shalala, supra, allowed for the possibility of an "exception to §405(h)'s bar in those cases where no judicial review is available at all." (App. A at 6a). The Third Circuit concluded, however, that the exception to the exhaustion requirement of administrative review was not available to petitioner because "Connor's failure to state a colorable constitutional claim precludes application of the Michigan Academy exception," id. at 7a, wherein the Supreme Court held that " 'a serious constitutional question' . . . would arise if we construed § 1395ii to deny a judicial forum for constitutional claims arising under Part B." Id.

Although the Third Circuit, in contrast to the district court, actually mentioned 42 CFR §405.817(a)(1) in its Opinion, it effectively confused the regulation at issue with §405.815, which establishes the various cutoff figures for levels of appeal following the carrier hearing ($500 for ALJ hearing; $1000 for judicial review) thereby creating the impression that petitioner was challenging this §405.817:

Citing Mitchell v. Occidental Ins. Medicare, 619 F.2d 28, 30 (9th Cir. 1980), the appellate court summarized the case accordingly as:

> "holding that $100 'cutoff for a right to a [carrier] hearing does not violate the Equal Protection Clause because Congress had a rational basis for this limitation,' namely the elimination of the administrative burden created by adjudication of small Medicare claims."

(App. A at 7a). However, petitioner is not challenging the $500 or $1,000 cutoffs in either the statute, 42 U.S.C. §1395(b)(2)(B), or its implementing agency regulation, 42 CFR §405.815. Petitioner *is* challenging §405.817(a)(1)'s method of computing the amount in controversy, which determines eligibility for an ALJ hearing, under circumstances where a beneficiary is challenging the propriety of the entire billing in question. In other words, and in this case, petitioner is claiming that he *meets* the $500.00 requirement for purposes of an ALJ hearing and he is being barred from same by a regulation designed for another purpose, i.e., establishing how much more Medicare would be liable for on the claim in the event of further appeal. Accordingly, petitioner is claiming that this regulation cannot *rationally* be applied to petitioner's facts and circumstances, wherein he claims the right to challenge the doctor's $640 bill, in its entirety.

The above issues were presented to the Third Circuit in a Petition for Rehearing, which the appellate court denied on December 16, 2004. (App. E at 22-23a).

REASONS FOR GRANTING THE WRIT

I. Petitioner estate has a colorable constitutional claim with respect to its challenge to 42 U.S.C. §405.817(a)(1), as written and applied herein, under the Supreme Court's decision in Bowen v.

Mich. Academy of Family Physicians, 476 U.S. 667 (1986).

In Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986), the Supreme Court decided a case which, in several respects, closely parallels the estate's case, *infra*. The one major exception is that petitioner's case, *infra,* is not a "channeling" case and, hence, the case is not cited for that purpose. Otherwise, Michigan Academy, supra, supports the estate's Due Process and Equal Protection challenge to 42 U.S.C. §405.817(a)(1).

In Michigan Academy, supra, respondent physicians filed an original suit under 28 U.S.C. §1331 (general federal-question jurisdiction) challenging the validity of 42 CFR §405.504(b)(1985), which regulation authorized payment by Medicare in different amounts for similar physicians' services. The District Court, in ruling the regulation invalid, held:

> There is no basis to justify the segregation of allopathic family physicians from all other types of physicians. Such segregation is not rationally related to any legitimate purpose of the Medicare statute. To lump MD's who are family physicians, but who have chosen not to become board certified family physicians for what-ever motive, with chiropractors, dentists, and podiatrists for the purpose of determining Medicare reimbursement defies all reason.

Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan, 502 F.Supp. 751, 755 (E.D. Mich. 1980). (Emphasis added). (The District Court, ruling the regulation invalid on statutory grounds, did not decide the respondents' constitutional claim). The Court of Appeals for the Sixth Circuit affirmed, holding that the regulation "irrational

and * * invalid." Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan, 728 F.2d 326, 332 (C.A. 6, 1984). (The appellate court also did not decide respondents' constitutional claims).

The Government in Michigan Academy, supra, argued that Congress had precluded judicial review of all questions involving the "amount of benefits" under Part B of the Medicare program. Under 42 U. S.C. §1395ff(b) (1982), claimants under Part B, in contrast to Part A, were not authorized judicial review as to "amount of benefits." Id., at 673. Further, the Government contended that 42 U.S.C. §1395ii (1982) made applicable 42 U.S.C. §405(h) of the Social Security Act to the Medicare program. And under §405(h), "[n]o action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to *recover on any claim* arising under this subchapter." Id. at 679 (Emphasis added).

In sustaining jurisdiction under 28 U.S.C. §1331, the Supreme Court found that "the reticulated statutory scheme * * * simply does not speak to challenges mounted against the *method* by which such amounts are to be determined rather than the *determinations* themselves." Id. at 675. (Emphasis added). The Court also added: "[a]s the Secretary has made clear, 'the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare program' is not considered in a 'fair hearing' held by the carrier to resolve a grievance related to a determination of the amount of a Part B award." Id. at 675-676. In support of its position, the Court cited to the Medicare Carrier's Manual §12016 (1985), which states that the "[h]earing officer * * * is to comply with all the provisions of title XVIII of the Act and regulations issued thereunder * * * [and] * * * may not overrule the provisions of the law or interpret them in a way different than HCFA does when he disagrees with their intent." Id. at 676, note 5.

The Court, in Michigan Academy, supra, found it "implausible to think [Congress] intended that there be *no* forum to adjudicate statutory and constitutional challenges to regulations promulgated by the Secretary." Id. at 678. (Emphasis in original). Additionally, the Court stated: "[b]y the same token, matters which Congress did *not* delegate to private carriers, such as challenges to the validity of the Secretary's instructions and regulations, are cognizable in courts of law." Id. at 680. (Emphasis in original). Further, the Court held that:

> "[W]e will not indulge the Government's assumption that Congress contemplated review by carriers of 'trivial' monetary claims * * * but intended no review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program."

Id. at 680. The Court, citing Weinberger v. Salfi, 422 U.S. 749, 762 (1975) (citing Johnson v. Robinson, 415 U.S. 361, 366-367 (1974)) stated that its disposition in Michigan Academy, supra, "avoids the 'serious constitutional question' that would arise if we construed §1395ii to deny a judicial forum for constitutional claims arising under Part B of the Medicare program." Id. at 681, at Note 12.

Finally, the Court addressed the physicians' constitutional challenges to Medicare regulation §405.504(b) with these words:

> "Finally, we cannot, as the Government would have us, dismiss respondents' constitutional attack as insubstantial – that is to say, 'essentially fictitious,' 'obviously frivolous,' and 'obviously without merit' – under *Hagans v. Lavine*,

> 415 U.S. 528, 537 (1974) (internal quotations omitted), as would be necessary to decline jurisdiction over the case. Both courts below found the classification embodied in the regulation to be 'irrational,' see *supra*, at 668-669, and although this finding was made with respect to respondents' statutory claims, it surely casts sufficient doubt on the constitutionality of the classification under the Due Process and Equal Protection Clauses to merit resolution of the constitutional challenge.

Id. at 681-682, Note 12. (Emphasis added).

Bowen v. Michigan Academy, supra, was decided by the Supreme Court on June 9, 1986. four months later, Congress amended the Medicare Act to allow Part B claimants the same administrative and judicial review remedies previously available to Part A claimants, subject to certain amount-in-controversy thresholds, for services rendered after January 1, 1987.

Subsequently, in Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (2000), the Supreme Court revisited the issue of whether 42 U.S.C. §405(h) barred federal court jurisdiction under §1331. The appellants in Shalala, supra, had filed an original §1331 suit prospectively challenging, on statutory and constitutional grounds, certain Medicare regulations that tightened the standards Medicare imposes on nursing homes. The Supreme Court ruled that in this case, "the statutory provision at issue, §405(h), as incorporated by §1395ii, bars federal-question jurisdiction here," id. at 5, and that the "association or its members must proceed instead through the special review channel that Medicare statutes create. See 42 U.S.C. §§ 1395cc(h), (b)(2)(A), 1395ii; §§405(b, (g), (h)." Id.

In its Opinion, the Supreme Court found that the Michigan Academy "methodology" exception was not available to appellants, who, post-1987 amendments to Part B claims, were now eligible for further administrative and judicial review, beyond the previously-allowed carrier "fair hearing." The Court, while not reversing its Michigan Academy ruling, restated it's holding accordingly:

> Regardless, it is more plausible to read *Michigan Academy* as *holding* that § 1395ii does not apply § 405(h) where application of § 405(h) would not simply channel review through the agency, but would mean no review at all.

Shalala, supra, at 19. (Emphasis in original). The Court found that the "no review at all" caveat did not apply to appellants, who could present their case to the agency prior to federal court review: "[t]he Council's members remain free, however, after following the special review route that the statutes prescribe, to contest in court the lawfulness of any regulation or statute upon which an agency determination depends. The fact that the agency might not provide a hearing for that *particular contention*, or may lack the power to provide one, see Sanders, 430 U.S., at 109 [Califano v. Sanders, 430 U.S. 99 (1977)] ("Constitutional questions obviously are unsuited to resolution in administrative procedures. . .") * * * is beside the point because it is the 'action' arising under the Medicare Act that must be channeled through the agency. See *Salfi, supra*, at 762. After the action has been so channeled, the court will consider the contention when it later reviews the action. And a court reviewing an agency determination under §405(g) has adequate authority to resolve any statutory or constitutional contention that the agency does not, or cannot decide (citations omitted)." Shalala, supra, at 23. "At a minimum, however, the matter must

be presented to the agency prior to review in a federal court. This the Council has not done." Id. at 24.

In its Opinion, the Third Circuit variously found that: "Connor is required to 'channel' his claim through the review procedures and requirements of the Medicare Act," App. A at 6a; and, "the Michigan Academy exception is not available because Connor has failed to state a colorable constitutional claim." Id. at 7a. The appellate court's Opinion is predicated upon the false premise that petitioner has not already "channeled" the estate's challenge to 42 CFR §405.817(a)(1) through the agency when, in fact, that claim has exhaustively gone through the agency Medicare review route, at *every* level, from the "fair hearing" stage up to and including the Medicare Appeals Council and *been ruled on.* See: Appendices H, I, J, K, L, and M at 30-58a. Consequently, the Third Circuit's reliance on the "channeling" cases is egregiously erroneous. See: Clarinda Home Health v. Shalala, 100 F.3d 526 (8th Cir. 1996) (Exception to exhaustion requirement not available); Fanning v. U.S., 346 F.3d 386 (3rd Cir. 2003) (Federal question jurisdiction not available to class action plaintiff's who did not proceed through special review channel Medicare statutes created).

In contrast to the Third Circuit's statement that petitioner has failed to "state a colorable constitutional claim," App. A at 7a, petitioner submits that the Supreme Court's discussion of the constitutional challenge in Michigan Academy, supra, validates the estate's challenge, infra. In the estate's case, as in Michigan Academy, petitioner is challenging a Medicare regulation, 42 U.S.C. §405.817(a)(1), on constitutional (due process and equal protection) grounds under 28 U.S.C.

§1331.[6] As previously explained in petitioner's Statement of Facts, infra at p. 13, the regulation contains *no* alternative provision for a beneficiary who elects to challenge the entirety of a physician's bill or, as stated by Medicare Fair Hearings: "the fact that any Medicare payment was issued." (App. M at 56a).

Not to overlook ALJ Determan's comment that "[petitioner] has a colorable argument concerning satisfaction of the amount in controversy requirement." (App. J at 36a). ALJ Determan succinctly summarized the limitations of the agency's "amount in controversy" formula in his decision:

> "The formula does not contemplate situations in which a party contends the amount previously billed is too high. It only considers how much has been billed on a claim, how much Medicare has allowed on the claim and how much more Medicare could potentially pay on the claim."

(App. J at 37a). Thus, there is no room in §405.817(a)(1) for beneficiaries who elect to challenge the (100%) totality of an award to a physician by Medicare. Petitioner submits that since the propriety of the entire ($640) billing was "the" issue before Medicare Fair Hearings, then that issue needs remains "the" issue on further appeal to an ALJ in this case.

Aside from the fact that the estate is liable for *another* primary care physician's bill (Tucker), in order for the estate to

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[6] Petitioner also cited 42 USC §1395ff(b)(2)(B) in the estate's Third Amended Complaint as a basis for jurisdiction, predicated upon a waiver of the $1,000 threshold for judicial review. The issue was not addressed by the Third Circuit.

void its (20%) liability under the entire ($640) bill, of necessity it must challenge the bill in its (100%) entirety, and not any (20%) part thereof, which, as computed by Medicare, amounts to $121.98.[7]

In its Opinion, the Third Circuit cited to the case of Mitchell v. Occidental Ins. Medicare, 619 F.2d 28 (9th Cir. 1980) holding that "[the] $100 'cutoff for a right to a [carrier] hearing does not violate the Equal Protection Clause because Congress had a rational basis for this limitation,' namely the elimination of the administrative burden created by adjudication of small Medicare claims." (App. A at 7a). The citation is inapposite because the estate, in its challenge to §405.817(a)(1) is not challenging the $100 (fair hearing), the $500 (ALJ hearing) or the $1,000 (judicial review) cutoff figures. Petitioner estate is, in fact, claiming that it meets, as well as, exceeds the $500 threshold for administrative review due to its challenge to the entirety of the $640.00 physician's bill. The estate is challenging the *method* whereby that cutoff figure is arrived at under §405.817(a)(1) in petitioner's facts and circumstances.

What the Supreme Court is confronted with, *infra*, is a case of first impression insofaras there is no previous case, of record, involving a constitutional challenge to §405.817(a)(1), certainly on the grounds that petitioner is advancing, i.e., a challenge to the 100% entirety of Medicare's award to a physician versus a beneficiary attempting to increase its award from Medicare. However, the Court's opinion in Michigan Academy, supra, comes sufficiently close to be precedential, not only in its allowance of a §1331 challenge to a Medicare

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[7] "The amount in controversy in this case as defined by statute and regulation, is $121.98 [actual amount charged ($640) less payment made by carrier ($487.52) less any deductible ($0) or coinsurance ($0)]. Since the amount in controversy is less than $500, there is no right to a hearing before an Administrative Law Judge." App. H at 31-32a.

regulation but also in its characterization of the lower courts' finding with respect to the challenged classification, which bears repeating:

> "Both courts below found the classification embodied in the regulation to be 'irrational' * * * and although this finding was made with respect to respondents' statutory claims, it surely casts sufficient doubt on the constitutionality of the classification under the Due Process and Equal Protection Clauses to merit resolution of the constitutional challenge.

Id, at 682, Note 12. Petitioner estate submits that if the "lumping" of family physicians with chiropractors, dentists and podiatrists for Medicare reimbursement purposes merited resolution of the constitutional challenge to §405.504(b) in Michigan Academy, then so does the "lumping" of a beneficiary challenging the entirety of a physician's submission to Medicare along with claimants attempting to increase their awards, merit no less of a result. The challenged regulation, §405.817(a)(1) *infra* impermissibly combines two different groupings within its classification, to the constitutional detriment of petitioner estate which is being denied its claimed right to an ALJ hearing in this matter.

II. Federal judicial review of the within matter can be sustained under 28 U.S.C. §1331, 42 U.S.C. §405(g) or 42 U.S.C. §1395ff(b)(2)(B).

The Supreme Court has stated that 42 U.S.C. §405(h) "purports to make exclusive the judicial review method set forth in §405(g)." Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1, 10 (2000). The second sentence of the statute

states that "[n]o findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided." §405(h). Its third sentence states that "[n]o action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to *recover on any claim* arising under this subchapter." Id. (Emphasis added).

As defined in Shalala, supra, the words "to recover on any claim" apply in a typical Social Security or Medicare benefit case, "where an individual seeks a *monetary benefit* from the agency (say, a disability payment, or payment for some medical procedure), the agency denies the benefit and the individual challenges the lawfulness of that denial. The statute plainly bars §1331 review in such a case, irrespective of whether the individual challenges the agency's denial on evidentiary, rule-related, statutory, constitutional , or other legal grounds." Id. (Emphasis added). Though the actual question in Shalala, supra, dealt with the case-specific issue of whether a future, prospective challenge to a regulation constituted an action "to recover on any claim arising under" the Medicare or Social Security Acts, the definition of the phrase covers the case, *infra.*

The simple fact of the matter is that petitioner-estate is *not* attempting to recover a monetary benefit from the agency, but to the contrary, is attempting to *void* one. As previously explained in the Statement of Facts, infra, petitioner has already received a benefit in the form of an award of Medicare monies to the primary care physician he hired (Tucker) for the March 30 to April 7, 2000 period in question and the estate should not have to be obligated to pay for an additional primary care physician (Profeta), who resigned and was replaced by the former for the designated period of time. Such a result surely violates 42 U.S.C. §1395y(a)(1)(A), which states that "no payment may be made under Part A or Part B * * * for any expense incurred for items or services * * * which * * * are

not reasonable and necessary for the diagnosis or treatment of illness or injury." Id.

Consequently, because petitioner-estate is not seeking to recover a "monetary benefit" from Medicare, the third sentence of §405(h) barring a §1331 action against the Secretary in not applicable to this case, and the federal courts may exercise §405(g) jurisdiction herein, as occurred in Matthews v. Eldridge, 424 U.S. 319 (1976). As discussed in Shalala, supra, Eldridge "is a case in which the Court found that the respondent *had followed* the special review procedures set forth in § 405(g), thereby *complying with*, rather than *disregarding*, the strictures of § 405(h). See *id.*, at 326-327 (holding jurisdiction available only under § 405(g)). Id., at 15. (Emphasis in the original). The Court, in Shalala, supra, found that "§ 405(g) contains the nonwaivable and nonexcusable requirement that an individual present a claim to the agency before raising it in court * * * [t]he Council has not done so here and thus cannot establish jurisdiction under § 405(g)." Id.

Not so with the estate, *infra*, which has presented its claim to the agency challenging 42 CFR §405.817(a)(1), in addition to the merits of its case, *before* it was presented to the District Court for review. Hence, the estate is not barred from asserting jurisdiction under §1331 for judicial review, as well as §405(g), in accordance with the decision in Matthews v. Eldridge, supra.

In addition to the above statutes, petitioner estate is eligible for review under 42 U.S.C. §1395ff(b)(2)(B), upon court waiver of the statute's $1,000 jurisdiction threshold. Such waivers are not unknown in district courts. In Bartlett v. Heckler, 576 F.Supp. 830 (D.C.D.C. 1983), the plaintiff challenged 42 U.S.C. §1395x(y)(2)(B), which denied "reimbursement to a patient receiving extended care services in a non-Christian Science nursing facility if, during the same spell

of illness, the patient previously received extended care in a Christian Science facility." Id., at 831. Plaintiff-executrix, whose amount-in-controversy was only $286.00, could not meet the jurisdictional minimum of $1,000 for judicial review and argued that the "different standards violate[d] the free exercise clause of the First Amendment and the equal protection and due process clauses of the Fifth Amendment." Id., at 831.

Relying on Johnson v. Robinson, 415 U.S. 361 at 366-367 (1974), the court concluded that if all judicial review of plaintiff's claims were precluded, "the most serious constitutional questions would be present. The Court has, of course, a duty to avoid such questions if it is possible to do so." Bartlett, supra, at 833. The Court concluded that, despite plaintiff's failure to satisfy the $1,000 jurisdictional minimum, that it could exercise general question jurisdiction under 28 U.S.C. §1331 "because plaintiff's claim is based on the Constitution and because there is no alternative method of securing judicial review of her claim. Id. at 831. (Emphasis added). *See also:* McCuin v. Secretary of Health and Human Services, 817 F.2d 161 (1st Cir. 1987) (affirming a decision of the District Court for New Hampshire holding that the district court possessed jurisdiction over a challenge to administrative interpretation of the Secretary's reopening regulations under either mandamus or federal question jurisdiction, although plaintiff did not meet the $1,000 minimum for judicial review). The First Circuit held that "jurisdiction is particularly appropriate here in view of the constitutional challenge to the Secretary's interpretation of the regulations." Id.

Petitioner estate is in an identical position, challenging a regulation of the Secretary on constitutional grounds. The estate has asserted jurisdiction under 42 U.S.C. §1395ff(b)(2)(B) in its Third Amended Complaint *infra* and submits that it is similarly entitled to a waiver of the $1,000 threshold minimum for judicial review.

The Third Circuit Court of Appeals is not unfamiliar with the applicability of §1331 federal question jurisdiction to matters not within the statutory jurisdiction of Medicare hearing officers. In Medical Fund-Philadelphia Geriatric Center v. Heckler, 804 F.2d 33 (3rd Cir. 1986), the Third Circuit reinstated a suit to "permit the plaintiff to amend its complaint to allege jurisdiction under 28 U.S.C. §1331." Id., at 35. The appellate court decided that what plaintiff was actually claiming was that by requiring "place of service of plaintiff's professional services as a condition of payment, to be performed in a Medicare-certified facility, which, in fact, is already Medicaid-certified, is agency rule-making *in excess of statutory authority*" Id., at 38. (Emphasis added). The Third Circuit deemed these implied assertions to amount to a claim that the Secretary's position was "contrary to law." Id.

Similarly, in American Ambulance Service v. Sullivan, 911 F.2d 901 (3rd Cir. 1990), the Third Circuit reversed a dismissal for lack of subject matter jurisdiction in a case where the plaintiff-provider's challenge to a Medicare Part B recoupment determination was deemed a challenge to the rule, itself. In its decision, wherein it deemed appellant's challenge to Medicare reimbursement methods a "colorable" one, id., at 910, the Court quoted from Michigan Academy, supra:

> "[M]atters which Congress did *not* delegate to private carriers, such as challenges to the validity of the Secretary's instructions and regulations, are cognizable in courts of law."

Michigan Academy, supra, at 680. (Emphasis in original).

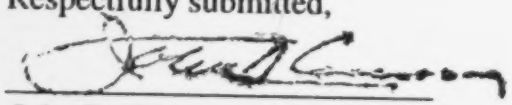
Petitioner's constitutional challenge to 42 CFR §405.817(a)(1) merits a similar jurisdictional result in the Third Circuit, under circumstances wherein there is no bar to the

introduction of petitioner's DNR order (App. N at 59a) into evidence on the dispositive issue of which of the two doctors was decedent's primary care physician during the March 30 - April 7, 2000 period at issue.

CONCLUSION

For reasons aforesaid, Petitioner prays that the Supreme Court should grant the estate's petition for certiorari and issue its writ to the Third Circuit Court of Appeals.

Respectfully submitted,



John R. Connor, Executor pro se
Estate of Helen T. Hanlon

Dated: 16 March, 2005

APPENDIX "A"
(Filed: October 14, 2004)

UNREPORTED - NOT PRECEDENTIAL

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

NO: 04-1122

JOHN R. CONNOR, Executor of Helen T. Hanlon,

Appellant,

v.

*JO ANNE B. BARNHART, Commissioner of the Social Security Administration; TOMMY G. THOMPSON, Secretary of the Department of Health and Human Service

*(Amended in accordance with Clerk's Order dated 3/16/04)

On Appeal From the United States District Court
for the District of New Jersey
(D.N.J. Civ. No. 02-cv-5072)
District Judge: Honorable Dennis M. Cavanaugh

Submitted Under Third Circuit LAR 34.1(a)
August 18, 2004
Before: AMBRO, SMITH AND VAN ANTWERPEN,
CIRCUIT JUDGES

(Filed October 14, 2004)

OPINION

PER CURIAM

John R. Connor appeals pro se a District Court order granting the defendants' motion to dismiss his complaint for lack of subject matter jurisdiction. For the reasons below, we will affirm.

In early March 2000, Connor's cousin, Helen T. Hanlon, was admitted to Overlook Hospital in Summit, New Jersey, where she received treatment from Dr. Susan Profeta, her primary care physician. Shortly thereafter, Hanlon fell into a coma. On March 30, Dr. Profeta resigned from Hanlon's case due to an apparent disagreement with Connor, who, as Hanlon's Health Care Representative, was making medical decisions for her. Nevertheless, Dr. Profeta visited Hanlon eight times until her death on April 7, 2000, and billed Medicare carrier $640 for those visits. The Medicare carrier reimbursed Dr. Profeta for the allowable amount of $487.52 (8 visits x $60.94 per visit).

Connor, now the executor of Hanlon's estate, appealed that determination to a Medicare hearing officer, alleging that no payment should have been made to Dr. Profeta for her services from the time of her resignation until Hanlon's death. The Medicare hearing officer upheld the carrier's decision, finding that "[s]ince the primary care of Helen Hanlon was never officially turned over to [another doctor], Dr. Profeta had a legal and moral obligation to continue treating and providing comfort measures for this patient until her death." Medicare Hearing Decision, July 31, 2001, at 3. Connor then appealed to

an administrative law judge ("AlJ"), who dismissed the case for lack of jurisdiction because the amount in controversy, $121.98, was less than $500.[1] See 42 C.F.R. § 405.815 (providing that "[t]o be entitled to a hearing before an ALJ following the carrier hearing, the amount remaining in controversy must be $500 or more."). Connor requested review of the ALJ's decision by the Medicare Appeals Council, but the Council declined to review the case, stating that the ALJ had correctly determined Connor's claim did not meet the amount in controversy requirement. See Action of Medicare Appeals Council on Request for Review of Dismissal, Aug. 16, 2002.

On October 21, 2002, Connor filed in the District Court a complaint, which he later amended, alleging that the regulations governing the amount in controversy are invalid as applied to his case and that the denial of a hearing before an ALJ violated his constitutional right to due process under the Fifth Amendment. The government moved to dismiss the complaint pursuant to Fed. R. Civ. P. 12(b). The District Court granted the government's motion, concluding that it lacked subject matter jurisdiction because the amount in controversy was less than the $1000 statutory threshold required for judicial review, see 42 U.S.C. § 1395ff(b)(1)(E)(i), and because Connor failed to state a valid constitutional claim. After his motion for reconsideration was denied,[2] Connor appealed.

We have jurisdiction pursuant to 28 U.S.C. § 1291. Our review of the District Court's order granting the government's

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[1] The formula for calculating the amount in controversy is set forth in 42 C.F.R. §405.817(a)(1). The amount in controversy in this case represents 80% of the difference between the amount billed and the amount approved for coverage.

[2] In its opinion denying the reconsideration motion, the District Court clarified that it also dismissed the Commissioner of Social Security from the case pursuant to Fed. R. Civ. P. 21.

motion to dismiss is plenary. See Gould Elecs. Inc. v. United States, 220 F.3d 169 (3d Cir. 2000); Piecknick v. Commonwealth of Pennsylvania, 36 F.3d 1250, 1255 (3d Cir. 1994).

The Medicare Act sets forth a carefully detailed and virtually exclusive method for obtaining judicial review of Medicare claims. "No action against the United States, the [Secretary of Health and Human Services], or any officer or employee thereof shall be brought under section 1331 of 1346 of Title 28 to recover on any claim arising under this subchapter." 42 U.S.C. § 405(h) (made applicable to the Medicare Act by 42 U.S.C. § 1395 ii). Jurisdiction over "claims arising under" the Medicare Act exists under 42 U.S.C. § 405(g), which, to the exclusion of the federal-question jurisdiction statute, 28 U.S.C. § 1331, "is the sole avenue for judicial review." Heckler v. Ringer, 466 U. S. 602, 614-15 (1984). Signifigantly, under the Medicare Act, a dissatisfied beneficiary can seek federal court review only after the administrative review process is complete and if the amount in controversy is $1000 or more. See 42 U.S.C. § 1395ff(b) (incorporating by reference § 405 (g)).

Connor concedes that the amount in controversy in this case is less than the $1000 threshold for judicial review provided in 42 U.S.C. § 1395ff(b)(1)(E)(i). He argues, however, that he is not subject to the $1000 amount in controversy requirement because his claim does not arise under the Medicare Act, but rather involves a constitutional challenge.[3] Therefore,

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[3] Connor asserts that "42 C.F.R. § 405,817 (a)(1) violates due process and equal protection." Appellant's Brief, 17. As noted above, this regulation sets out the formula for calculating "whether an appellant meets the minimum amount in controversy needed for a carrier hearing ($100) or ALJ hearing ($500)." It provides that "[t]he amount in controversy is computed as the actual amount charged the individual for the items and services in question, less any amount for which payment has been made by the carrier and less

(continued on following page)

according to Connor, § 405 (h) does not prevent the District Court from exercising § 1331 jurisdiction over his complaint.

A similar argument was rejected by the Supreme Court in Shalala v. Illinois Council on Long Term Care, Inc., 529 U. S. 1, 12-13 (2000). There, members of an association of nursing homes brought an action under § 1331 alleging that certain Medicare regulations violated various statutory requirements as well as the Constitution. In holding that federal question jurisdiction was barred under § 405 (h), as incorporated by § 1395ii, the Court recognized that the "bar did not 'preclude constitutional challenges,' but simply 'require[d] that they be brought' under the same 'jurisdictional grants' and 'in conformity with the same standards' applicable 'to nonconstitutional claims arising under the Act.'" Id. at 11 (quoting Weinberger v. Safli, 422 U.S. 749, 762 (1975)). This is so even where the challenge is to agency procedures and the relief requested amounts simply to a declaration of invalidity (not a benefit determination or review of a benefit determination). Id. at 12 (citing Ringer, 466 U. S. at 614-16). In short, § 405(h) applies "where both the standing and the substantive basis for the presentation" of a claim is the Medicare Act. Id. at 11, 12.

The basis of Connor's claim, which was brought in connection with his appeal of the carrier's initial determination, is that 42 C.F.R. § 405.817(a)(1)'s amount in controversy formula unconstitutionally precludes administrative review where the allegation is that no Medicare payment should have

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any deductible and coinsurance amounts applicable in the particular case." § 405.817 (a)(1). Connor complains that the regulation makes no provision for administrative review where, as here, the claimant contends that no amount should have been charged and therefore that the payment made by the carrier was too high.

been issued. As such, under the Supreme Court's broad interpretation of § 405(h), the claim arises under the Medicare Act. Therefore, § 405(h) deprived the District Court of federal question jurisdiction. See Fanning v. United States, 346 F.3d 386, 399-400 (3d Cir. 2003). Connor is required to "channel" his claim through the review procedures and requirements of the Medicare Act.

The Supreme Court in Illinois Council did, however, recognize an exception to §405(h)'s bar in those cases where no judicial review is available at all. See Fanning, 346 F.3d at 399. This exception derives from Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986), wherein the Supreme Court held that § 405(h) did not prevent the District Court from having federal question jurisdiction over the complaint of an association of family physicians who challenged a Medicare regulation which authorized payment of Part B benefits in different amounts for similar services. Id. at 680. Notably, the challenge to the regulations was not administratively or judicially reviewable under the Medicare Act at the time.[4] See Fanning, 346 F.3d at 396, 399. Accordingly, the Supreme Court in Illinois Council stated that "it is more plausible to read Michigan Academy as holding that § 1395ii does not apply

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[4] Michigan Academy was decided before the Medicare Act was amended in 1987 to afford individuals challenging Medicare Part B determinations the same administrative and judicial review remedies as individuals challenging Part A determinations. Prior to those amendments, the Medicare Act provided that benefit amount determinations could be challenged only by way of a hearing before the private carrier; the Act did not provide for any administrative or judicial review of Part B claims. See Fanning, 346 F.3d at 397-98. The Court noted in Michigan Academy, however, that "those matters which Congress did *not* leave to be determined in a 'fair hearing' conducted by the carrier - including challenges to the validity of the Secretary's instructions and regulations - are not impliedly insulated from judicial review by. . . § 1395ff." Michigan Academy, 476 U. S. at 678.

§ 405(h) where application of § 405(h) would not simply channel relief through the agency, but would mean no review at all." Illinois Council, 529 U.S. at 17-19 (noting concern expressed in Michigan Academy that "'a serious constitutional question'. . . would arise if we construed § 1395ii to deny a judicial forum for constitutional claims arising under Part B." 476 U.S. at 681, n. 12 (quoting Salfi, 422 U.S. at 762)).

Connor argues that he does not have an alternative method for securing judicial review of his constitutional claim. However, we conclude that the Michigan Academy exception is not available because Connor has failed to state a colorable constitutional claim. See Clarinda Home Health v. Shalala, 100 F.3d 526, 531 (8th Cir. 1996) (holding that because the temporary withholding of Medicare payments without a hearing is not a colorable constitutional claim, exception to administration exhaustion requirement did not apply). In this case, Connor has provided no basis upon which to conclude that the amount in controversy definitions in 42 C.F.R. § 405.817(a)(1), are, by themselves, unconstitutional. Cf. Mitchell v. Occidental Ins. Medicare, 619 F.2d 28, 30 (9th Cir. 1980) (holding that $100 "cutoff for a right to a [carrier] hearing does not violate the Equal Protection Clause because Congress had a rational basis for this limitation," namely, the elimination of the administrative burden created by adjudication of small Medicare claims). Connor asserts that the "constitutional issue in this case is simply too obvious not to be recognized." Appellant's Brief, 17. We disagree. As the government maintains, merely stating that the definition of "amount in controversy" impermissably prevents him from "challenging the totality of a physician's bill" is not sufficient. Connor's failure to state a colorable constitutional claim precludes application of the Michigan Academy exception.

Accordingly, for the foregoing reasons, we will affirm the judgment of the District Court.

APPENDIX "B"
(Filed: October 14, 2004)

UNITED STATES COURT OF APPEAL
FOR THE THIRD CIRCUIT
NO: 04-1122

JOHN R. CONNOR,
Executor of Helen T. Hanlon,

Appellant

v.

*JO ANNE B. BARNHART, Commissioner of the Social Security Administration; TOMMY G. THOMPSON, Secretary of the Department of Health and Human Service

*(Amended in accordance with Clerk's Order dated 3/16/04)

On Appeal From the United States District Court
for the District of New Jersey
(D.N.J. Civ. No. 02-cv-5072)
District Judge: Honorable Dennis M. Cavanaugh

Submitted Under Third Circuit LAR 34.1(a)
August 18, 2004

Before: AMBRO, SMITH AND VAN ANTWERPEN,
CIRCUIT JUDGES

JUDGMENT

This cause came on to be heard on the record from the United States District Court for the District of New Jersey. On consideration whereof, it is now here

ORDERED AND ADJUDGED by this Court that the judgment of the District Court entered on December 12, 2003, be, and the same is, hereby AFFIRMED.

Costs taxed against appellant. All of the above in accordance with the Opinion of the Court.

ATTEST:

/s/ Kathleen Brower
Chief Deputy Clerk

DATED: October 14, 2004

APPENDIX "C"
(Filed: October 16, 2003)

NOT FOR PUBLICATION

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

JOHN R. CONNOR, Executor of the Estate of Helen T. Hanlon,	:	**Hon. Dennis M. Cavanaugh**
Plaintiff,	:	**OPINION**
v.	:	
	:	Civil Action No. 02-5072 (DMC)
JO ANNE B. BARNHART, Commissioner of the Social Security Administration, and TOMMY G. THOMPSON, Secretary of the Department of Health and Human Services,	:	ORIGINAL FILED Oct. 16, 2003 WILLIAM T. WALSH, CLERK
Defendants.	:	

DENNIS M. CAVANAUGH, U.S. District Judge

This matter comes before the Court on a motion by Defendants, Jo Anne B. Barnhart and Tommy G. Thompson, to dismiss the Third Amended Complaint pursuant to Rule 21 of the Federal Rules of Civil Procedure. The motion was decided without oral argument pursuant to Rule 78 of the Federal Rules

of Civil Procedure. For reasons set forth below, the motion is **granted.**

FACTUAL BACKGROUND

Plaintiff, John R. Connor ("Plaintiff"), is the executor of the Estate of Helen T. Hanlon, ("Hanlon") his deceased cousin. In 1996, Hanlon appointed Plaintiff to be her Health Care Representative and provided him with Power of Attorney. Hanlon's Living Will and Health Care Directive authorized Plaintiff to hire and discharge physicians to care for her. Plaintiff's Third Amended Complaint, ¶ 7.

On or about March 9, 2000, Hanlon became ill and was admitted to Overlook Hospital in Summit, New Jersey where she received treatment in the intensive care unit until her death on April 7, 2000. *Id.*, at ¶8. Shortly after her admittance Hanlon suffered a Coumadin bleed and eventually fell into a coma, which adversely impacted her kidney function. *Id.* During Hanlon's hospitalization, Dr. Susan Profeta ("Dr. Profeta") acted as her primary care physician. *Id.* On or about March 30, 2000, Dr. Profeta contacted Plaintiff and advised him that she was resigning from Hanlon's case because of an apparent disagreement over the manner in which Plaintiff was carrying out the terms of Hanlon's Advance Care Directive. *Id.* Consequently, Plaintiff contacted the services of another physician for Hanlon. On or about March 31, 2000, Dr. Profeta asked to return as the decedent's primary care physician but Plaintiff declined the offer. *Id.*, at ¶ 10. Despite the aforementioned, Dr. Profeta allegedly continued to attend to Hanlon until her death. *Id.*, at ¶ 9.

During the time from her resignation as Hanlon's primary care physician, March 30, 2000, through Hanlon's death on April 7, 2000, Dr. Profeta billed Medicare for eight visits at a rate of $80 per visit, totaling $640. *Id., at* ¶ 12. These visits were

to be paid by Medicare. Plaintiff disputes any payment to Dr. Profeta for her services from the time of her resignation as Hanlon's primary care physician through Hanlon's death. *Id.* On May 5, 2000, Empire Medical Services, the Health Insurance Carrier, paid the disputed claim at 80% for each visit, for a total payment of $487.52 of the $640.00 billed amount. *Id.*, at ¶ 13.

Plaintiff challenged the disputed claims through the available administrative proceedings. Dissatisfied with the results, Plaintiff now seeks a review of these administrative proceedings, asks this Court to set aside the administrative orders and decisions in this case and grant him a hearing on the merits before the Administrative Law Judge ("ALJ"). Alternatively, Plaintiff urges this Court to conduct a *de novo* hearing. Gov't brief at page 2.

PROCEDURAL HISTORY

On May 5, 2000, Empire Medical Services paid the disputed claim at 80% for each visit, totaling $487.52 of the $640 billed. Pl's 3d Amd. Comp., ¶ 13. Plaintiff appealed the decision to Medicare Fair Hearings and contested the entirety of Dr. Profeta's billings for the disputed period. *Id.* On or about July 31, 2001, Medicare Fair Hearings found Dr. Profeta to be Hanlon's primary care physicia[n] during the disability period. *Id.*, ¶ 15. Medicare Fair Hearings also found that Plaintiff never turned primary care over to another physician and that Dr. Profeta properly billed Medicare. *Id.* The Hearing officer found that only $121.98 remained in controversy, which was below the required amount for a plaintiff to appeal to an ALJ. *Id.*

On or about August 13, 2001, plaintiff filed a Motion for Reconsideration, which the Hearing Office granted to the extent that Plaintiff was given an opportunity for oral testimony to support his motion. Id. A telephone hearing was conducted on September 20, 2001, between the Hearing Officer,

Plaintiff and Dr. Profeta. *Id.* On September 25, 2001, the Hearing Officer denied the motion for reconsideration despite the new evidence and testimony introduced at the hearing because it did not change the overall outcome of the original hearing. *Id.*, at ¶ 17.

On October 2, 2001, the Social Security Act's Office of Appeals received an ALJ hearing request from Plaintiff. *Id.*, Exhibit E. On March 12, 2002, the Social Security Act's Office of Hearings and Appeals issued an Order dismissing Plaintiff's appeal because the amount remaining in controversy was less than $500 and insufficient for a hearing before an ALJ. *Id.*, Exhibit F. On August 16, 2002, Medicare Appeals Council denied Plaintiff's request for review of the ALJ's March 12, 2002, Order of Dismissal. *Id.*, Exhibit H. On September 17, 2002, the ALJ convened a Notice of Hearing. *Id.*, at ¶ 23. On September 25, 2002, Medical Fair Hearings denied the estate's Motion for Reconsideration. *Id.*, ¶ 23. Plaintiff then filed a Complaint in this Court alleging that his denial of a hearing before an ALJ violated his constitutional right to due process under the Fifth Amendment to the United States Constitution. *Id.*, at ¶ 28.

In his Complaint, Plaintiff originally named only the Commissioner of Social Security ("Commissioner") as a defendant. However, this matter is a Medicare claims dispute, thus the proper party in interest is the Secretary of Health and Human Services ("Secretary"), not the Commissioner. After receipt of the Second Amended Complaint, Defendants' counsel contacted Plaintiff to inform him that the Commissioner was not the correct defendant and requested that he voluntarily dismiss the action because the court lacked subject matter jurisdiction. Plaintiff then filed a Third Amended Complaint and added the Secretary, but failed to remove the Commissioner as a defendant. Accordingly, the Commissioner and the Secretary filed this motion to dismiss.

DISCUSSION

The government seeks to dismiss Plaintiff's Complaint for lack of subject matter jurisdiction pursuant to Section 1395ff of the Social Security Act, which provides that if the amount in controversy is less than $1,000 judicial review shall not be available to any individual. 42 U.S.C. § 1395ff(b)(2) (2002). Plaintiff admits that the amount in controversy is $121.98, thus not satisfying the jurisdictional minimum.

Plaintiff claims that, notwithstanding § 139[5]ff, his denial of a hearing before the ALJ violated his constitutional right to due process of law guaranteed him under the Fifth Amendment to the United States Constitution. Plaintiff also argues that since his claim is based on the Constitution and because there is no alternative method of securing judicial review of his claim, this Court is not barred from exercising jurisdiction over his claim. Contrary to Plaintiff's claims, this Court holds that it lacks jurisdiction in the instant case because the amount in controversy, $121.98, falls well below the statutory threshold.

The Social Security Act provides that "the findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such a hearing ... no findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided." 42 U.S.C. § 405(h)(2002). The Social Security Act also provides that "any individual dissatisfied with any determination under subsection (a) of this section as to the amount of benefits under part A shall be entitled to a hearing thereon by the Secretary ... and to judicial review of the Secretary's final decision after such a hearing is provided." 42 U.S.C. § 1395ff (b). However, § 1395ff(b)(2)(c) also states that, "if the amount in controversy is less than $1,000 judicial review shall not be available."

In addition, the Supreme Court has never held that Congress may foreclose all judicial review of the constitutionality of a congressional enactment and has noted the problems that would ensue if it did. *See Bartlett v. Bowen*, 816 F.2d 695, 704 (D.C. Cir. 1986). When addressing constitutional claims under § 1395ii in *Bowen v. Michigan Academy of Family Physicians*, the Supreme Court recognized the constitutional dangers avoided in holding that "our disposition avoids the serious constitutional claims arising under Part B of the Medicare Program." *Id.*, 476 US 667, 704, 106 S.Ct. 2133, 2140 (1986).

Although difficult questions do exist concerning Congress' Article III power to limit federal court jurisdiction, most scholars agree that "under the Due Process clause of the Fifth Amendment Congress may not exercise Article III power over the jurisdiction of the federal courts in order to deprive a party of a right created by the Constitution." *Bartlett*, 816 F.2d 695, 704.

Courts apply a clear and convincing standard when constitutional rights form the basis of the action over which judicial review is sought. *Id.*, at 698. The Supreme Court has indicated that only the clearest expression of congressional intent to proscribe judicial review of constitutional claims will suffice to overcome the presumption that Congress wants to face the constitutional dangers inherent in denying a forum in which to argue that government action has injured interests protected by the Constitution. *Id.* "Indeed, it has become something of a time honored tradition for the Supreme Court and lower federal courts to find that Congress did not intend to preclude judicial review of constitutional claims altogether in light of the serious due process concerns that such preclusion would raise." *Id.*, at 699.

In this case, however, it appears that Congress did in fact intend to preclude judicial review of claims that are less than the $1,000 statutory minimum or have not met the administrative exhaustion requirement. Congress enacted the adminstrative exhaustion requirement and minimum dollar amount of § 1395ff as a unified scheme to protect the federal courts from overload by having all statutory exceeding a claim for $1,000 to be passed on to the courts for review. *Id.* at 701. The legislative history of the Act implies that the scheme is designed to take advantage of the Secretary's expertise and to save the courts from re-litigating minor matters. *Id.* However, the Court recognized that deferring to the Secretary's expertise by requiring complete exhaustion of administrative procedures proves fruitless when the agency lacks the authority to rule on the disputed issue. *Id.* Even the Secretary has acknowledged this fact by adopting a regulation waiving the statute's administrative exhaustion requirement when the only factor precluding an award of benefits is a statutory provision that the claimant challenges as unconstitutional. *Id.* Such claims must still go through the administrative process in order for the Secretary to address any matters within his or her expertise and possibly obviate the need for judicial review of the constitutional claim. *Id.*

Mere challenges to the constitutionality of the Medicare Act itself may be reviewed in federal court consistent with congressional intent as expressed in § 1395ff. *Id.* at 702. This does not afford much opportunity for frivolous claims since aggrieved claimants must find a way to connect their claims for benefits to a constitutional infirmity found in the Medicare Act itself. *Id.* "A court can still dismiss, for lack of subject matter jurisdiction, cases raising immaterial, wholly unsubstantiated or frivolous claims." *Id.* The $1,000 amount in controversy requirement for judicial review was meant to sort out claims so that courts would be the final arbitrator in some cases, while the Secretary would have the final word in others. *Id.*

The Supreme Court addressed these issues in *Johnson v. Robinson*, 415 U.S. 361, 94 S.Ct. 1160 (1974). The Supreme Court held that challenges to the constitutionality of the Veterans' Administrator Act were reviewable despite language in the statute that made "the decisions of the Administrator on any question of law or fact under the law administered by the Veterans' Administration final and conclusive." *Id.* at 367. The Court found the constitutional claim reviewable because the "decision" at issue was that of Congress in enacting the statute rather than a "law administered by the Veterans' Administration." *Id.* at 373. The *Robinson* Court concluded that the no review clause could not and was not meant to bar challenges to the constitutionality of the Act itself. *Bartlett*, 816 F.2d at 697. The Court also noted that such challenges "cannot be expected to burden the courts by their volume, nor do they involve technical considerations of Veterans' Administration policy." *Robinson*, 415 U.S. at 373.

Plaintiff's claim differs from *Johnson* in that there is no constitutional issue for this Court to decide. Plaintiff alleges that Defendant's denial of his right to a hearing before an ALJ constitutes a denial of his constitutional right to due process of law under the Fifth Amendment. (Pl's 3d Amd. Compl., at ¶ 7).

The Fifth Amendment states that no person "shall be deprived of life, liberty, or property without due process of law." U.S. CONST. amend. V. Due process guarantees that there is a *fair* decision-making process before official action is taken which directly impairs a person's life, liberty or property. *In Re Complaint of Bankers Trust Co.*, 752 F.2d 874, 887 (3d. 1984). The Supreme Court has held that there is not a deprivation of due process if the plaintiff seeks a post-deprivation remedy for the loss of liberty or property resulting from a random and unauthorized act of a government officer and the state provides an adequate post-deprivation remedy. *See Paratt v. Taylor*, 451

U.S. 527, 68 L.Ed.2d 420 (1981); *Bonner v. Couglin*, 517 F.2d 1311 (CA 7 1975).

In the instant case, Plaintiff claims that Dr. Profeta fraudulently billed Medicare for medical visits to the decedent. (Pl's 3d Amd. Compl., at ¶ 12.) Empire Medical Services paid the disputed claim at 80% for each visit for a total of $487.52 of the $64[0] billed, leaving Plaintiff to pay the $121.98 balance. (*Id.* at ¶ 13.)

Plaintiff is not alleging a violation of due process because he is seeking only a post-deprivation remedy for the $121.98 balance. The laws of the State of New Jersey provide adequate avenues for such remedies. This case does not involve an issue of pre-deprivation due process; there is nothing that Empire Medical Services could have done to prevent the doctor from billing the decedent. Rather, the alleged loss resulted from Dr. Profeta's acts, thus making a post-deprivation claim.

Plaintiff claims that the instant case resembles *Bartlett v. Heckler*, 576 F. Supp. 830 (D.C. Cir. 1983). In *Bartlett*, the plaintiff challenged a provision of the Medicare Act, 42 U.S.C. § 1395x(y)(2)(B), which denies reimbursement to a patient receiving extended care services in a non-Christian Science skilled nursing facility if, during the same spell of illness, the patient previously received extended care in a Christian Science facility. The decedent in that case spend thirty days in a Christian Science home, for which she was reimbursed. *Id.* at 831. Decedent then entered a non-Christian Science skilled nursing facility, where she received twenty-two days of extended care. *Id.* Due to the above mentioned rule, the plaintiff was denied reimbursement for this case. *Id.* Plaintiff exhausted the administrative remedies and claimed that the different standards violated the Free Exercise Clause of the First Amendment and the Equal Protection and Due Process Clauses of the Fifth Amendment. The government also moved

to have the plaintiff's claim dismissed on the basis that the court lacked subject matter jurisdiction for failing to satisfy the $1,000 minimum requirement set forth in 42 U.S.C. § 1395ff (b)(2). *Id.* The court ruled that because the plaintiff made a constitutional based claim with no alternative method of securing judicial review, there was no bar from exercising jurisdiction over the lawsuit. *Id.*

The instant case differs from *Bartlett* in that Plaintiff has failed to make a valid constitutional claim. Further, unlike in *Bartlett*, Plaintiff has an alternate method of securing judicial review in New Jersey Superior Court. Thus, this Court is barred from exercising jurisdiction over the instant claim.

CONCLUSION

A plaintiff who fails to satisfy the $1,000 minimum requirement cannot then claim that his constitutional rights have been violated in order to secure proper subject matter jurisdiction when no constitutional claim in fact exists. *See Bartlett*. As explained, Plaintiff's constitutional rights have not been violated and there is an available forum in New Jersey Superior Court to adjudicate his claims. Therefore, for this reason and the reasons stated above, there was no violation of due process. Accordingly, Plaintiff's claim is dismissed for lack for lack of subject matter jurisdiction.

Based on the foregoing, the motion by Defendants to dismiss the Third Amended Complaint pursuant to Rule 21 of the Federal Rules of Civil Procedure is **granted**. An appropriate Order accompanies this Opinion.

/s/ Dennis M. Cavanaugh
DENNIS M. CAVANAUGH,
U.S.D.J.

Dated: October 15, 2003

APPENDIX "D"
(Filed: October 16, 2003)

NOT FOR PUBLICATION

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

JOHN R. CONNOR, Executor of the Estate of Helen T. Hanlon,

Plaintiff,

v.

JO ANNE B. BARNHART, Commissioner of the Social Security Administration, and TOMMY G. THOMPSON, Secretary of the Department of Health and Human Services,

Defendants.

Hon. Dennis M. Cavanaugh

ORDER

Civil Action No. 02-5072 (DMC)

DENNIS M. CAVANAUGH, U.S. District Judge

This matter comes before the Court on a motion by Defendants, Jo Anne B. Barnhart and Tommy G. Thompson, to dismiss the Third Amended Complaint pursuant to Rule 21 of the Federal Rules of Civil Procedure. The motion was decided without oral argument pursuant to Rule 78 of the Federal Rules of Civil Procedure. The Court having considered the papers submitted in support thereof and in opposition thereto, and for good cause shown:

IT IS on this 15th day of October, 2003;

ORDERED that Defendants motion to dismiss is **granted** for the reasons set for in the Court's Opinion filed this day.

/s/ Dennis M. Cavanaugh, U.S.D.J.
DENNIS M. CAVANAUGH, U.S.D.J.

Original: Clerk

Copies: Hon. Mark Falk, U.S.M.J.
All counsel of record
File

APPENDIX "E"
(Filed: December 16, 2004)

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Case No: 04-1122

JOHN R. CONNOR, Executor
Estate of Helen T. Hanlon,

Appellant

v.

*JO ANNE BARNHART, Commissioner
of the Social Security Administration;
TOMMY G. THOMPSON, Secretary of the
Department of Health and Human Services

*(Amended in accordance with the Clerk's Order dated 3/16/04)

SUR PETITION FOR REHEARING

Present: SCIRICA, Chief Judge, SLOVITER, NYGAARD, ALITO, ROTH McKEE, RENDELL, BARRY, AMBRO, FUENTES, SMITH, CHERTOFF, FISHER and VAN ANTWERPEN, Circuit Judges

The petition for rehearing filed by appellant in the above-entitled case having been submitted to the judges who participated in the decision of this Court and to all the other available circuit judges of the circuit in regular active service,

and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular service not having voted for rehearing, the petition for rehearing by the panel and the Court en banc, is denied.

BY THE COURT,

/s/ D. Brooks Smith
Circuit Judge

Dated: December 16, 2004
CMD/CC: John R. Connor
Anthony J. LaBruna, Jr., Esq.

APPENDIX "F"
(Filed: December 11, 2003)

NOT FOR PUBLICATION

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

JOHN R. CONNOR, Executor of the Estate of Helen T. Hanlon,	**Hon. Dennis M. Cavanaugh**
Plaintiff,	**OPINION**
v.	Civil Action No. 02-5072 (DMC)
JO ANNE B. BARNHART, Commissioner of the Social Security Administration, and TOMMY G. THOMPSON, Secretary of the Department of Health and Human Services,	
Defendants.	

DENNIS M. CAVANAUGH, U.S. District Judge

This matter comes before the Court on Plaintiff John R. Connor's motion for reconsideration pursuant to Rule 59(e) of the Federal Rules of Civil Procedure and Local Rule 7.1(g) of this Court's October 16, 2003, Opinion and Order granting Defendants' motion to dismiss the Third Amended Complaint pursuant to Rule 21 of the Federal Rules of Civil Procedure. The motion was decided without oral argument pursuant to Rule 78 of the Federal Rules of Civil Procedure. After careful

review of the party's submissions and based upon the following, Plaintiff's motion for reconsideration is **denied.**

BACKGROUND

On October 16, 2003, this Court granted Defendant's motion to dismiss. On October 31, 2003, Defendant filed a motion for reconsideration of the October 16, 2003, Order and Opinion pursuant to Local Civil Rule 7.1(g). The facts in this matter are described in detail in this Court's October 16, 2003, Opinion. See Connor v. Barnhart, et al., Civil Action No, 02-5072 (D.N.J. October 16, 2003).

Local Rule 7.1(g) requires the moving party to "set[] forth concisely the matters or controlling decisions which counsel believes the [court] has overlooked." L.Civ.R. 7.1(g). A motion under Rule 7.1(g) may be granted if: (1) "an intervening change in the controlling law has occurred; (2) evidence not previously available has become available; or (3) it is necessary to correct a clear error of law or prevent manifest injustice." Database America, Inc. v. Bellsouth Advertising & Pub. Corp., 825 F.Supp. 1216, 1220 (D.N.J. 1993); North River Ins. Co. v. CIGNA Reinsurance Co., 52 F.3d 1194, 1218 (3d Cir 1995). Relief by way of motion for reargument is "an extraordinary remedy" that is to be granted "very sparingly." See NL Indus. Inc. v. Commercial Union Ins. Co., 935 F. Supp. 513, 516 (D.N.J. 1996); Maldonado v. Lucca, 636 F. Supp. 621, 630 (D.N.J. 1986). Local Rule 7.1(g) governing reconsideration does not contemplate a recapitulation of arguments considered by the court before rendering its decision. See Bermingham v. Sony Corp. of Am., Inc., 820 F. Supp. 834, 856 (D.N.J. 1992), aff'd, 37 F.3d 1485 (3d Cir. 1994); Cartaret Sav. Bank, F.A. v. Shushan, 721 F. Supp. 705, 709 (D.N.J. 1989). Rather, the rule permits a reconsideration only when "dispositive factual matters or controlling decisions of law" were presented to the court but overlooked. See Resorts Int'l v. Great Bay Hotel and Casino,

830 F. Supp. 826, 831 (D.N.J. 1992); Khair v. Campbell Soup Co., 893 F. Supp. 316, 337 (D.N.J. 1995). In sum, it is improper on a motion for reconsideration to "ask the Court to rethink what it had already thought through - rightly or wrongly." Oritani Sav. & Loan Ass'n v. Fidelity & Deposit Co., 744 F. Supp. 1311, 1314 (D.N.J. 1990).

After careful consideration, this Court must deny Plaintiff's motion for reconsideration. Plaintiff has not demonstrated to the Court that (1) an intervening change in the controlling law has occurrred; (2) evidence not previously available has become available; or (3) it is necessary to correct a clear error of law or prevent manifest injustice. Database America, Inc., 825 F. Supp. at 1220. Basically, Plaintiff is asking this Court to analyze the same issue again and come to a different resolution. This is not a proper use of Local Civil Rule 7.1(g). Accordingly, Plaintiff's motion for reconsideration is **denied.**

Further, Plaintiff requests this Court issue an amended Order regarding the basis for dismissal. There is no practical difference in the basis for dismissal between the October 16, 2003, Order and the proposed Order submitted by Plaintiff. However, this Court shall issue an amended Order clarifying the October 16, 2003, basis for dismissal.[1]

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[1] The October 16, 2003, Order should have granted Defendants' motion to dismiss for lack of subject matter jurisdiction under Fed. R. Civ. P. 12(b)(1) and granted Defendants' unopposed motion to dismiss Defendant Joanne Barnhart, Commissioner of the Social Security Administration, under Fed. R. Civ. P. 21.

CONCLUSION

For the foregoing reasons, Plaintiff's motion for reconsideration of this Court's Opinion and Order is **denied**. Plaintiff's request for an amended Order is also **denied**. An appropriate Order accompanies this Opinion.

APPENDIX "G"
(Filed: December 11, 2003)

NOT FOR PUBLICATION

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

JOHN R. CONNOR, Executor of the Estate of Helen T. Hanlon,	**Hon. Dennis M. Cavanaugh**
Plaintiff,	**ORDER**
v.	Civil Action No. 02-5072 (DMC)
JO ANNE B. BARNHART, Commissioner of the Social Security Administration, and TOMMY G. THOMPSON, Secretary of the Department of Health and Human Services,	
Defendants.	

DENNIS M. CAVANAUGH, U.S. District Judge

This matter comes before the Court on a motion by Defendant John R. Connor for reconsideration of this Court's October 16, 2003, Opinion and Order. The Court having carefully reviewed the record; and for the reasons stated in this Court's Opinion filed herewith; and for good cause shown:

IT IS on this 11th day of December 2003;

ORDERED that Plaintiff's motion for reconsideration is **denied**; and it is further

ORDERED that Defendants' motion to dismiss for lack of subject matter jurisdiction pursuant to Federal Rule of Civil Procedure 12(b)(1) is **granted** for the reasons stated in this Court's Opinion filed October 16, 2003; and it is further

ORDERED that Defendants' unopposed motion to dismiss Defendant JoAnne Barnhart, Commissioner of Social Security Administration, pursuant to Federal Rule of Civil Procedure 21 is **granted** for the reasons stated in this Court's Opinion filed October 16, 2003.

/s/ Dennis M. Cavanaugh
DENNIS M. CAVANAUGH, U.S.D.J.

Original: Clerk
Copies: Hon. Mark Falk, U.S.M.J.
All counsel of record
File

APPENDIX "H"
(Filed: March 12, 2002)

SOCIAL SECURITY ADMINISTRATION

Office of Hearing and Appeals

ORDER OF DISMISSAL

In the case of	Claim for
JOHN CONNOR, EXECUTOR OF ESTATE	Supplementary Medical Insurance (Part B)
(Appellant)	(Claim Type)
HELEN HANLON (deceased)	144-07-1551A
(Beneficiary)	(HICN)
EMPIRE MEDICAL SERVICES	999-16-7599
(Carrier)	(Docket Number)

This case is before the Administrative Law Judge (ALJ) on a request for hearing dated November 25, 2001.

- The request for hearing concerns payment for medical services furnished to the beneficiary from March 30, 2000 until her death on April 7, 2000. The appellant, the executor of the beneficiary's estate, objects to a specific doctor being paid for eight (8) hospital visits during this period of time, because he understood that he and the doctor had agreed that she was no longer to be the primary care physician for the beneficiary. It appears that although there may have been an agreement to

change the primary care physician, no such change took effect before the beneficiary's death, and this doctor continued to provide care to the beneficiary.

The hospital (sic) billed Medicare for the services rendered, and the carrier paid 80% of the total billed amount ($640) or $487.52. The appellant objected, and the carrier requested further documentation from the hospital (sic). When the hospital (sic) did not respond, a determination was made against them (sic). The hospital (sic) then requested a fair hearing and substantiated the billing for the visits. Because the appellant was unable to testify at the fair hearing, a subsequent reconsideration hearing (reopening case #91-01226-066-000) was held. This case arised from an appeal of the re-hearing decision.

Section 1869(b)(2)(B) of the Social Security Act states, in pertinent part, that "under Part B, a hearing shall not be available to an individual . . . if the amount in controversy is less than $500."

The centers for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration) regulations at 42 CFR §405.817(a)(1) state, in pertinent part, that "the amount in controversy is computed as the actual amount charged the individual for the items and services in question, less any amount for which payment has been made by the carrier and less any deductible and coinsurance amounts applicable in the particular case." In addition, the CMS regulations reiterate that "[t]o be entitled to a hearing before an ALJ following carrier hearing, the amount in controversy remaining in controversy must be $500 or more. . ." 42 CFR §405.815.

The amount in controversy in this case, as defined above by statute and regulation, is $121.98 [actual amount charged ($640)

less payment made by carrier ($487.52) less any deductible ($0) or coinsurance ($0)]. Since the amount in controversy is less than $500, there is no right to a hearing before an Administrative Law Judge. Although the defendant argues that since he is disputing the total amount billed of $640, this should be the amount in controversy, the law and regulations clearly indicate otherwise.

Accordingly, the request for hearing is denied and the case is dismissed for lack of jurisdiction. The carrier hearing decision remains in effect.

/s/ Robert S. Habermann
ROBERT S. HABERMANN
ADMINISTRATIVE LAW JUDGE-IN-CHARGE
Division of Medicare

DATE: March 12, 2002

APPENDIX "I"
(Filed: August 16, 2002)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary
Departmental Appeals Board
Medicare Operations Division
Room 633-F, HHH Building
200 Independence Avenue, S. W.
Washington, D. C. 20201

August 16, 2002

144-07-1551, HIC Number
999-16-7599, Docket Number

ACTION OF MEDICARE APPEALS COUNCIL ON
REQUEST FOR REVIEW OF DISMISSAL

John Connor
Executor of Estate
380 Wyoming Avenue
Millburn, N. J. 07041

Re: Dates of service: March 30, 2000 through April 7, 2000

Dear Mr. Connor:

The Medicare Appeals Council has considered the request for review of the Administrative Law Judge's order of dismissal dated March 12, 2002.

The regulations provide that the Medicare Appeals Council will grant a request for review of a dismissal where: (1) there appears to be an abuse of discretion by the Administrative Law Judge; (2) there is an error of law; (3) the Administrative Law Judge's action, findings, or conclusions are not supported by

substantial evidence; or (4) there is a broad policy or procedural issue that may affect the general public interest. The regulations also provide that where new and material evidence is submitted with the request for review, the entire record will be evaluated and review will be granted where the Council finds that the Administrative Law Judge's action, findings, or conclusion is contrary to the weight of the evidence currently of record. *See* 20 CFR 404.970 and the notices published in the Federal Register on December 13, 1995 (60 FR 64065) and May 12, 1997 (62 FR 25844, 25849).

The Administrative Law Judge correctly applied 42 CFR 405.817(a)(1) in determining the appellant's claim did not meet the amount in controversy requirement for a hearing before an Administrative Law Judge. Therefore, the Medicare Appeals Council concludes that there is no basis under the above regulations for granting the request for review of the dismissal of the request for hearing.

The request is therefore denied.

Sincerely Yours,

/s/ Bruce Gipe
Bruce Gipe
Administrative Appeals Judge

APPENDIX "J"
(Filed: October 21, 2002)

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals
DECISION

IN THE CASE OF	CLAIM FOR
	Supplemental Medical Insurance Benefits
Estate of Helen T. Hanlon (Appellant)	(Part B)
Helen T. Hanlon (Dec'd) (Beneficiary)	144-07-1551 (HICN)
Empire Medical Services (Carrier)	999-15-2138

Paramount Medical Group, Dr. Susan Profeta
(Provider)

INTRODUCTION

This claim is before the Administrative Law Judge on a timely request for a hearing filed by John R. Connor, the executor of the beneficiary's estate, on October 2, 2001 (Exhibit 7). Mr. Connor is dissatisfied with a July 31, 2001 Fair Hearing decision extending coverage for 8 visits by Dr. Profeta (of Paramount Medical Group) to the beneficiary from March 30 through April 7 of 2000. The threshold issue is whether the $500 amount in controversy requirement for an Administrative Law Judge hearing under the Medicare Part B program (42 CFR § 405.815) is satisfied. For the reasons explained below, the Administrative Law Judge finds that the amount remaining in controversy is less than $500. Therefore, the Administrative

Law Judge does not have jurisdiction to adjudicate the substantive issue(s) presented in this claim.

PROCEDURAL HISTORY

Paramount Medical Group accepted assignment of the beneficiary's claim for the visits in question. Paramount Medical Group then billed Medicare Part B $80 for each visit, a total of $640. After carrier reviews were completed and a Fair Hearing was conducted, the Medicare Hearing Officer (MHO) decided, on July 31, 2001 that the visits all were covered, that the allowable amount was $487.52 ($60.94 per visit) and that, considering the beneficiary's estate liability for coinsurance of 20% of the allowed amount, Medicare Part B was supposed to pay $390.01 for the services. The MHO subsequently received a motion from Mr. Connor to reconsider her decision, as well as additional evidence, but she decided on September 25, 2001 that the conditions to reopen her decision were not satisfied (Exhibit 6).

EVALUATION OF THE EVIDENCE

Mr. Connor maintains that the entire $640 remains in controversy because he believes that Dr. Profeta should not have made the visits in question, let alone billed for them, because Dr. Profeta told him before she provided the services in question that she had to resign as the beneficiary's primary physician if he disagreed with the plan of care that she proposed, and Mr. Connor obtained the agreement of another doctor to serve as the beneficiary's primary physician the same day and notified Dr. Profeta's office by telephone that he had done so. Since Mr. Connor has a colorable argument concerning satisfaction of the amount in controversy requirement, the Administrative Law Judge held a hearing on both the amount in controversy and, for the sake of efficiency in the event the amount in controversy requirement was

satisfied, the substantive issue of whether the visits in question were medically necessary and reasonable. Mr. Connor appeared and testified. Also testifying were Pilar Kerr, who handles billing for Paramount Medical Group, and Max Yablonsky, M.D., an impartial medical expert. The hearing took place in Newark, New Jersey on September 17, 2002.

Despite the fact that Mr. Connor contests every penny of the doctor's $640 bill, and has explained in considerable detail why he does not believe that any portion of the services shoud be covered, The Centers for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration (HCFA) has published a regulation that specifies how to compute the amount in controversy for purposes of determing whether a party has the right to an Administrative Law Judge hearing. The formula does not contemplate situations in which a party contends that the amount previously approved is too high. It only considers how much has been billed on the claim, how much Medicare has allowed on the claim and how much more Medicare could potentially pay on the claim. For individuals appealing carrier hearing decisions, "[t]he amount in controversy is computed as the actual amount charged the individual for the items and services in question, less any amount for which payment has been made by the carrier, less any deductible and coinsurance amounts applicable in the particular case" (42 CFR §405.817(a)(1). The Administrative Law Judge is bound to apply the rule in determing the amount in controversy. Applying the formula, the amount in controversy is only $121.98 ($640 billed minus $487.52 allowed by the carrier, minus 20% of the difference, which the beneficiary would be liable to pay as coinsurance if the full difference were allowed ($30.50). No deductibles apply to the services in question.

The Administrative Law Judge-In-Charge of the Office of Hearing and Appeals Divison of Medicare reached the same

conclusion regarding the amount in controversy on March 12, 2002, in connection with a request for a hearing that Mr. Connor filed on November 25, 2001 appealing the MHO's September 25, 2001 decision not to reopen her July 31, 2001 decision. The Adminsitrative Law Judge determined that, because the amount in controversy requirement was not satisified, he had no jurisdiction in the case. He accordingly dismissed the November 25, 2001 request for a hearing without reaching the question of whether the MHO's denial to reopen her decision was appealable (Docket Number 999-16-7599) (Exhibit 20). The Medicare Appeals Council denied Mr. Connor's request for review of that dismissal, indicating that the Administrative Law Judge had correctly applied 42 CFR § 405.817(a)(1) in determining the amount in controversy (Exhibit 18).

Based upon the evidence in the record, the amount in controversy is less than $500. Therefore, the beneficiary's estate does not have the right to a hearing on the substantive issue.

FINDINGS

1. Based on the evidence in the record, the amount remaining in controversy on the claim for 8 visits by Dr. Profeta (of Paramount Medical Group) to the beneficiary from March 30 through April 7 of 2000 is $121.98.

2. The amount in controversy requirement for a hearing by an Administrative Law Judge is not satisified regarding the present claim (42 CFR § 405.817(a)(1).

3. The beneficiary's estate does not have the right to a hearing on the substantive issue(s) raised in this case (42 CFR § 405.815).

DECISION

It is the decision of the Administrative Law Judge that the amount in controversy requirement for an Administrative Law Judge hearing on the instant Medicare Part B claim is not satisfied. Therefore, the estate of the now-deceased beneficiary does not have the right to a hearing regarding the allowable amount for the 8 visits by Dr. Profeta (of Paramount Medical Group) to the beneficiary from March 30 through April 7 of 2000.

/s/ Dean W. Determan
DEAN W. DETERMAN
Administrative Law Judge
October 21, 2002
Date

APPENDIX "K"
(Filed: March 6, 2003)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Departmental Appeals Board
Medicare Operations Division
Room 633-F, HHH Building
200 Independence Avenue, S.W.
Washington, D. C. 20201

144-07-1551, HIC Number
999-15-2138, Docket Number

ACTION OF MEDICARE APPEALS COUNCIL ON REQUEST FOR REVIEW

John R. Conner, Executor
Estate of Helen T. Hanlon
380 Wyoming Avenue
Millburn, N. J. 07041

Dear Mr. Connor:

The Medicare Appeals Council has considered the request for review of the Administrative Law Judge's decision dated October 21, 2002. The decision concerns a claim for physician services furnished by Dr. Susan B. Profeta of the Paramount Medical Group to Medicare beneficiary Helen Hanlon during the period March 30, 2000 through April 7, 2000.

The regulations provide that the Medicare Appeals Council will grant a request for review of a decision where: (1) there appears to be an abuse of discretion by the Administrative Law Judge; (2) there is an error of law; (3) the Administrative Law Judge's action, findings, or conclusions are not supported by

substantial evidence; or (4) there is a broad policy or procedural issue that may affect the general public interest. The regulations also provide that where new and material evidence is submitted with the request for review, the entire record will be evaluated and review will be granted where the Council finds that the Administrative Law Judge's action, findings, or conclusion is contrary to the weight of the evidence currently of record. See 20 CFR 404.970, incorporated by reference in 42 CFR 405.856.

The Council has reviewed the request for review, dated December 26, 2002, as well as the record in the case. The Council notes that it previously considered this same matter and denied a prior request for review of another Administrative Law Judge's Order of Dismissal, dated March 12, 2002. See Letter from Administrative Appeals Judge Bruce P. Gipe, dated August 16, 2002. That action became final 60 days from date of receipt of the Medicare Appeals Council letter unless a civil action was filed in Federal district court. See 20 CFR 404.981. The Council is precluded from taking any further action with respect to the matter referenced in your request for review.

Accordingly, the Medicare Appeals Council has concluded that there is no basis under the above regulations for granting the request for review of the Administrative Law Judge's decision, dated October 21, 2002. The Administrative Law Judge's Order

of Dismissal, dated March 12, 2002, stands as the final decision of the Secretary.

Sincerely yours,

/s/ Thomas E. Herrmann
Thomas E. Herrmann
Administrative Appeals Judge

cc:
Susan B. Profeta, M. D.

APPENDIX "L"
(Filed: July 31, 2001)

MEDICARE
Part B Carrier

MEDICARE FAIR HEARINGS
P. O. Box 69212
Harrisburg, PA. 17106-3529

July 31, 2001
Case #: 91-01095-067-000

Paramount Medical Group
Attention: Pilar Kerr, Central Billing Office
P. O. Box 23957
Newark, N. J. 07189-0001

MEDICARE HEARING DECISION
RE: Helen Hanlon (deceased)
H.I. # 144-07-1551A
ICN - 0900108081520

AMOUNT IN CONTROVERSY: $390.01

Dear Ms. Kerr:

This letter contains my decision concerning the Medicare Part B hearing that was conducted by telephone on July 30, 2001 with Pilar Kerr from the Central Billing Office of Paramount Medical Group and who is the authorized representative for this Group.

FACTS

During the period of March 30, 2000 to April 7, 2000, Dr. Susan Profeta, a professional member of Paramount Medical

Group reported subsequent hospital visits (99232) @ a charge of $80.00 each for a total billed charge of $640.00 for Medicare Beneficiary, Helen Hanlon.

The Part B Carrier, Empire Medical Services, processed the assigned claim and initially made an allowance of $60.94 (paid @ 80%) for each of the 8 visits in dispute. Subsequently, the executor of the estate of Helen Hanlon, John R. Connor notified the Carrier that the visits from March 30, 2000 to April 7, 2000 were not performed by Dr. Profeta as he requested that another provider take over the primary care of Helen Hanlon. The Carrier requested hospital records from Dr. Profeta; however, they were not received within the time frame allotted for the receipt of the medical records. Consequently, a refund was issued to Paramount Medical Group in the amount of $390.01 for the 8 subsequent hospital visits in dispute.

ISSUES

Does the documentation submitted to the hearing office support the billiing for the 8 subsequent hospital visits in dispute?

Was the primary care of the deceased Helen Hanlon officially turned over to another provider of care during this hospitalization?

According to the hospital and Social Security records, who was the primary care physician responsible for the care of Helen Hanlon during her hospitalization?

CLAIMANT'S POSITION

Pilar Kerr, who is the biller and authorized representative for the purpose of this hearing for Dr. Profeta testified that she

was familiar with the case from haven (sic) spoken directly with Dr. Susan Profeta.

Ms. Kerr testified that Helen Hanlon was a patient of Dr. Profeta's since January of 1996 and was the primary care physician for Helen Hanlon during her entire hospitalization for the dates in question.

Ms. Kerr testified that there had been a dispute between Dr. Profeta and Mr. Connor, the cousin of Helen Hanlon, over the type of care that was being provided to his aunt (sic). The hospital records indicate that on March 30, 2000 Dr. Profeta spoke with Mr. Connor regarding further treatment being futile and not in the patient's best interest and not in agreement with the patient's advance directive. The records indicate that Dr. Profeta told Mr. Connor that she could not continue being the primary physician. Pilar Kerr testified that Dr. Profeta was not comfortable providing the type of care that was against the patient's advance directive. The records then indicate that Mr. Connor would get back to Dr. Profeta and that Dr. Profeta would continue to be available until a decision was made for a new primary care physician. The records further indicate that Mr. Connor advised Dr. Profeta that Dr. Tucker agreed to be the primary care physician. However, the actual transfer of the primary care never occurred and Dr. Profeta continued to handle the primary care of Helen Hanlon until her death on April 7, 2000.

FINDINGS

The Medicare law requires all billed services to be properly documented in the patient's medical records at the time the services are rendered. This means that evaluation and management services and all components of a surgical procedure or a diagnostic service should be adequately discussed in the formal record or procedure report. The

notations recorded on the office or hospital records must confirm that the servide was actually performed, was performed at the level reported, and was medically necessary for the condition reported. Information subsequently recorded in special reports, addendums, or the physician's records are of far less probative value than facts set forth in the operative or procedure reports. Judgment regarding the authenticity of supplemental data must be exercised because such records may be self-serving. If no valid documentation exists to support the billed service, payment may not be made.

I have carefully reviewed the oral testimony, letters from Mr. Connor, documentation of a telephone conversation that a member of the hearing office staff had with Mr. Connor, and the medical records from Overlook Hospital.

All of the documentation including the formal medical records indicate that there was some type of a discrepancy with Mr. Connor and Dr. Profeta regarding the care of Helen Hanlon. According to the records, Dr. Profeta had in fact told Mr. Connor to find a new primary care physician. The records indicate that Dr. Profeta did not want to go against the patient's advance directive for her care. The records further indicate that on March 31, 2000, Mr. Connor notified Dr. Profeta that Dr. Tucker, Renal Specialist, agreed to be the primary care physician. The records further indicate that although attempts had been made by Dr. Profeta to contact Dr. Tucker, the official transfer of the primary care never occurred. The hospital records further indicate that Dr. Profeta discussed providing comfort measures only with a cousin (name of cousin not mentioned in the records) on April 6, 2000. On April 7, 2000 the patient was pronounce dead by the resident on duty. The hospital records indicate that Dr. Profeta, who according to the hospital and the Social Security records was still the primary care physician, was to notify the family.

According to the official hospital and Social Security records, Dr. Susan Profeta was the primary care physician for Helen Hanlon during the hospitalization of March 10, 2000 to April 7, 2000. Since the primary care of Helen Hanlon was never officially turned over to Dr. Tucker, Dr. Profeta had a legal and moral obligation to continue treating and providing comfort measures for this patient until her death. The hospital records clearly indicate that Dr. Profeta made every attempt to contact Dr. Tucker and Dr. Goldstein (who was covering for Dr. Tucker at one point) for the transfer [of] the care; however, for whatever reason the official transfer never occurred. The records further prove that Dr. Profeta evaluated this patient and provided orders for each of the eight dates of service in dispute for this hearing. Therefore, Paramount Medical Group is entitled to Medicare reimbursement for the services rendered.

DECISION

In accordance with the authority set forth in §§1833(e) and 1870 of the Social Security Act, §§7100-7106 of the Medicare Carrier's Manual, and after a careful review of the medical records, I have determined that Dr. Susan Profeta was the primary care physician and the documentation supports the billing of the eight subsequent hospital visits in question.

Based upon the authority set forth in §1870 of the Social Security Act and §§7103.1E and H of the Medicare Carrier's Manual, the Carrier determined that Paramount Medical Group was liable for refunding the overpayment. However, the medical evidence confirms that the coverage criteria for the services were satisfied. Therefore, the Carrier shall return the $309.01 plus the applicable accrued interest that was offset from the Provider's account within 30 days of the date of this decision.

The ruling set forth herein is rendered under the Supplementary Medical Insurance Benefit Provisions of Title XVIII of the Social Security Act. It applies therefore only to the services and circumstances considered on the claim(s) in question in this hearing decision and does not create a precedent for any other Medicare claims or services. If you want copies of the Law, Regulations or policy on which the decision was based, you should notify me in writing within 30 days.

OTHER APPEALS

On the basis of this decision, I have determined that $121.98 ($640.00 - $487.52 = $152.48 X 80%) remains in controversy. This amount represents 80 percent of the difference between the amount billed and the amount approved for coverage. Since Medicare requires a minimum of $500.00 to be in question for an appeal to an administrative law judge (ALJ), the claim(s) does not meet this requirement. You may combine this claim(s) with other claims to meet the $500.00 amount in controversy. To do this, EACH CLAIM included in your request must have had a decision by a hearing officer and must be appealed within 60 days from the receipt of each decision.

Two or more doctors or suppliers may combine claims involving similar or related services rendered to a single Medicare beneficiary or may combine claims involving common issues of law and fact with respect to services furnished to multiple beneficiaries. They would have to file their appeal request within the appropriate time limit (60 days) for each claim they wish to include and each claim must have had a decision by a hearing officer.

If you decide to file an appeal, the request must be in writing and submitted within 60 days following the receipt of this notice. If you want help with your appeal, you may have

a friend, lawyer or someone help you. Some lawyers do not charge unless you win the appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aide services, that will provide free legal services if the party qualifies. An appeal request should be filed with this office of any Social Security Office.

Sincerely,

/s/ Lorraine Canfield
Lorraine Canfield
Medicare Hearing Officer

cc: John Connor
380 Wyoming Avenue
Millburn, N. J. 07041

EMPIRE MEDICARE SERVICES
NEW JERSEY OPERATIONS
300 East Park Drive, Harrisburg, Pennsylvania 17111
A HCFA Contracted Carrier

APPENDIX "M"
(Filed: September 25, 2001)

MEDICARE
Part B Carrier

MEDICARE FAIR HEARINGS
P. O. Box 69212
Harrisburg, PA. 17106-9212
(717) 565-3529
FAX (717) 565-3428

September 25, 2001

Reopening Case #91-01226-066-000
Original Case #91-01095-067-000

John R. Connor, Executor of
Estate of Helen T. Hanlon
380 Wyoming Avenue
Millburn, N. J. 07041

RE: MEDICARE HEARING DECISION
Helen T. Hanlon (deceased)
H. I. # 144-07-1551A
ICN - 0900108081520

Dear Mr. Connor:

This letter contains my decision concerning your motion for reconsideration of the hearing decision for Case number 91-01095-067-000. Additional written evidence was supplied and your oral testimony was taken by telephone on September 20, 2001. Dr. Susan Profeta also participated and provided oral testimony.

FACTS

During the period of March 30, 2000 to April 7, 2000, Dr. Susan Profeta, a professional member of Paramount Medical Group, reported subsequent hospital visits (99232) @ a charge of $80.00 each for a total billed charge of $640.00 for Medicare Beneficiary, Helen Hanlon.

The Part B Carrier, Empire Medicare Services, processed the assigned claim and initially made an allowance of $60.94 (paid @ 80%) for each of the 8 visits in dispute. Subsequently, the executor of the estate of Helen Hanlon, John R. Connor, notified the Carrier that the visits from March 30, 2000 to April 7, 2000 were not performed by Dr. Profeta as she had resigned from the case and he requested that another provider take over the primary care of Helen Hanlon. The Carrier requested hospital records from Dr. Profeta; however, they were not received within the time frame allotted for the receipt of the medical records. Consequently, a refund was issued to Paramount Medical Group in the amount of $390.01 for the 8 subsequent hospital visits in dispute.

Paramount Medical Group then requested a fair hearing, which was conducted by telephone on July 30, 2001 with Pilar Kerr from the Central Billing Office of Paramount Medical Group who was representing Dr. Susan Profeta. The hospital medical records were supplied to the hearing office and oral testimony was obtained on this date. Mr. Connor had indicated that he wanted to participate in the hearing; however, he would be out of the country between June 16th and July 3rd, 2001. Attempts were made to contact Mr. Connor by telephone and then a letter was sent to him advising him of the date and time of the hearing. Mr. Connor did not respond to the letter and did not participate in the telephone hearing conducted on July 31, 2001. The hearing decision was issued,

which was favorable to the claimant (Paramount Medical Group).

Subsequently, Mr. Connor contacted the hearing office with a motion for reconsideration and also advise that he was just returning from his trip on the evening of July 31, 2001 and did not receive the notice for the hearing date and time until the next day. Because Mr. Connor was not able to participate in the hearing, his motion was granted so that he had an opportunity to provide his written and oral evidence.

ISSUE

Does the medical documentation substantiate the billing to Medicare for the charges billed by Paramount Medical Group for Dr. Susan Profeta's services for the dates of March 30, 2000 to April 7, 2000 for the deceased Medicare Beneficiary, Helen T. Hanlon?

CLAIMANT'S POSITION

Mr. Connor testified that Dr. Profeta was the one who resigned from the case on March 30, 2000 and she requested that he find another primary care physician for Helen Hanlon. Mr. Connor indicated that the reason Dr. Profeta gave him for her resignation was that she felt that she would be going against Helen Hanlon's living will if whe were to treat Ms. Hanlon differently than what she was suggesting. It is important to note that Mr. Connor was given the authority in the living will to make all medical decisions for Ms. Hanlon if she could not make the decisions herself. Mr. Connor also indicated that Dr. Profeta had made the decision to resign after having received a letter from Ms. Hanlon's attorney. The letter dated March 28, 2000 notified Dr. Profeta that Mr. Connor's consent must be secured prior to the performance of any invasive procedures.

Mr. Connor also indicated that he had previously spoken with Dr. Tucker, the nephrologist, who was already one of the physicians working on Helen Hanlon's case, about being the primary care physician. Mr. Connor stated that he wanted Dr. Tucker to be the primary care physician because even prior to March 30, 2000 he felt Dr. Profeta was unduly negative when recommending treatment options.

Mr. Connor testified that he felt Dr. Profeta had exaggerated the implications of the spot on her lung and she had been pressuring him to agree to a DNR (do not resuscitate) order. Mr. Connor also stated that Ms. Hanlon had had medical problems in the past but she had always recovered and was quite an active woman and had traveled with him to Ireland. In fact, he indicated that they had another trip planned. Further, Mr. Connor also testified that he ordered an autopsy that showed there was a spot on the lung but it had not metastasized as Dr. Profeta was indicating.

Mr. Connor stated that after being notified by Dr. Profeta that she was resigning as the primary care physician, he immediately contacted Dr. Tucker. Dr. Tucker agreed to be the primary care physician if Ms. Hanlon were moved out of ICU. However, Dr. Tucker informed Mr. Connor that he did not believe Ms. Hanlon could survive the admission (move from ICU to a regular room). Mr. Connor indicated that he agreed to Dr. Tucker's terms; although as it turned out, Ms. Hanlon was never moved from the ICU.

Mr. Connor then testified that after speaking with Dr. Tucker, he placed a telephone call to Dr. Profeta and left a message with her secretary advising her that Dr. Tucker had agreed to become the primary care physician. Mr. Connor stated that he saw Dr. Profeta in the hallway the next day (March 31st) and she indicated to him that after thinking about it she decided she would like to come back on the case. Mr.

Connor stated that he thanked her, but told her that Dr. Tucker agreed to be the primary care physician and that if they needed her services they would let her know. Therefore, Mr. Connor does not feel that Dr. Profeta should be entitled to Medicare reimbursement for any of the services billed after her resignation from the case. Mr. Connor further indicated that since hospital medical records are written by the physicians, they may be self-serving. He indicated that he had no control of the information that was entered into the formal documentation.

Dr. Profeta then testified that she does not remember resigning from the case. She remembers indicating to Mr. Connor that he should seek another primary care physician if he would not agree to the type of care that she wanted to provide for Helen Hanlon, and that she was basing her treatment decisions on Ms. Hanlon's living will.

Dr. Profeta also indicated that she does remember Mr. Connor telling her that Dr. Tucker had agreed to take over as the primary physician. She then testified that she needed to confirm this information with Dr. Tucker and have the medical records officially changed prior to her coming off the case. She indicated that she was not able to confirm this information with Dr. Tucker or his associate, Dr. Goldstein. The medical records were never changed; and therefore, she continued to be the primary care physician until Ms. Hanlon passed on the 7th of April.

FINDINGS

Although the testimony from both parties was conflicting in parts, I believe that both parties were truthful in their testimony as to the way that they believed the events occurred. I believe that Mr. Connor felt that when Dr. Profeta told him to find another primary care physician and he had advised her

that he did, that he was of the opinion that Dr. Profeta was no longer on the case. I also believe that Dr. Profeta was waiting to hear from Dr. Tucker that he was officially taking over the case before discontinuing her daily care to Ms. Hanlon. Dr. Profeta indicated that she did not want to leave Ms. Hanlon in her condition without a primary care physician. Several entries in the hospital records indicate that Dr. Profeta had made attempts to contact Dr. Tucker to find out if he was officially taking over the case.

My decision must be based strictly on the medical records and the information that was suppleid to the Social Security Office by the hospital. A hearing officer does not have the authority to determine if the type of care provided was appropriate for the patient's medical condition. Further, a hearing officer must rely on the formal documentation when deciding which physician if any or all should be reimbursed based on the medical necessity of the care for each physician's participation in the case. Normal protocol for Medicare reimbursement is that the admitting/primary care physician is reimbursed for their services. The services of another physician of the same specialty treating the same condition are often questioned by Medicare as to the reason for their participation. Generally, when physicians of different specialties are treating different conditions, Medicare reimbursement may be issued to each specialist in addition to the primary care physician.

The hospital records indicate that Dr. Profeta was the admitting and primary care physician from the admission until Ms. Hanlon passed away on April 7, 2000. Dr. Profeta signed the death certificate. Social Security records indicate that Dr. Profeta was the "AT-Phys" which means that she admitted the patient and was the attending physician. Dr. Edward Dimitry is listed as the "OP-Phys", which means he was responsible for the operating or principal procedure. Dr. Dimitry is also listed

as the "OT-Phys:, which means other than the attending. The hospital records show that Dr. Tucker was never formally listed as the primary care physician. Further, the patient was never moved from the ICU to general admission. The formal hospital records sufficiently document the services billed by Paramount Medical Group for Dr. Profeta's care; therefore, Paramount Medical Group is entitled to Medicare reimbursement.

DECISION

§405.841(c)(2) of the Medicare Regulations provides that a hearing decision may be reopened to correct a clerical error or an error on the face of the evidence on which the decision had been issued. Although numerous additional written evidence and oral testimony was provided, the evidence and testimony does not change the overall overcome (sic) of the original hearing decision (i.e., Paramount Medical Group is entitled to Medicare reimbursement). Therefore, the decision may not be reopened.

FURTHER APPEALS

The decision to reopen a case file or accept additional evidence and testimony is a discretionary action on the part of the hearing officer and not an appeal right. Therefore, there are no additional appeal rights afforded and the next level of appeal offered in the original hearing decision stands. However, I would like to mention that Mr. Connor indicated in his testimony that he felt that he should be entitled to a hearing before an Administrative Law Judge if my decision was to not revise the original hearing decision. He stated that since he was disputing the $640.00 charge and the fact that any Medicare payment was issued, the next level of appeal for him should be based on the billed charge of $640.00. This would mean not basing the amount in controversy on the normal

protocol of the billed amount minus the allowed amount X 80 percent or in the case of a refund request on the amount of the refund.

I feel Mr. Connor made an excellent point regarding computing the amount in controversy for the next level of appeal based on the fact that he was disputing that any Medicare reimbursement was made to Dr. Profeta. Therefore, I am providing Mr. Connor with the information for filing an appeal before an administrative law judge (ALJ). I cannot guarantee that an ALJ will accept the case; only the ALJ has the authority to make that decision.

ALJ INFORMATION

If you remain dissatisfied with the hearing decision on this claim, you may request an in-person or on-the-record hearing before an administrative law judge (ALJ) of the Office of Hearings and Appeals of the Social Security Administration. If you want help with your appeal, you can have a friend, lawyer or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aide services, who will give you free legal services if you qualify. To receive such a hearing, you must file a written request within 60 days following receipt of this notice. You may file your request with this office or your local Social Security Office.

Sincerely,

/s/ Lorraine Canfield
- Lorraine Canfield
Medicare Hearing Officer

cc: Paramount Medical Group
Attn: Susan Profeta, M. D.
P. O. Box 23957
Newark, N. J. 07189-0001

APPENDIX "N"

Overlook Hospital
ATLANTIC HEALTH SYSTEM

DNR

DO NOT RESUSCITATE ORDER

HARLON,HELEN T
11/28/18 84Y
6548 DMITRY,EDWARD A JR
0007000002
00207301

Date Ordered: March 31, 2000 Date Rescinded: _____

(1) Diagnosis: VDRF

(2) Treatment Plan - check one of the following:
Specific Orders Must Be Written to cover any specified treatment
☐ A. Comfort and supportive care only.
☒ B. In addition to A: treatment of acute reversible processes: e.g., infection, GI obstruction, ~~vasopressors~~ 4/3H/00
☐ C. In addition to A + B: vigorous therapy: e.g., chemotherapy, transfusions, dialysis
Explain B or C, if desired: NO chest compressions, NO shock, NO meds for CPR

(3) Reason for DNR order (check all that apply):
☐ Condition irreversible; death imminent ☐ chronic debilitating disorder; quality of life unacceptable to patient
☐ condition irreversible; life expectancy <6 months ☐ requested by competent patient
☒ other (specify): requested by relative

(4) Decision-making capacity: ☐ Present ☒ Absent ☐ Variable ☐ Under age 18

(5) Discussion of DNR order has occurred with (check all that apply):
☐ Patient ☒ nursing staff
☒ family (specify): cousin (proxy) ☒ house staff
☐ surrogate decision maker (specify): _____
☐ other (specify): _____
If discussion has not taken place with patient or family, please state reason:

(6) Method of consent:
☒ Verbal (by whom) proxy
☐ written (Advance Directive, consent form or other statement)
☐ none obtained (please state reason) _____

(7) Physician:
SIGN: _____ MD
DATE: 3/31/2000 TIME: 9:10 a.m./p.m.

PLACE COMPLETED FORM IN DOCTOR'S ORDER SECTION

Upon discharge, DNR status should continue: ☐ Yes ☐ No ☐ Undecided
Specific orders must be written at time of discharge

BEST AVAILABLE COPY

DO NOT RESUSCITATE INFORMED CONSENT

(Optional)

In the event that my heart should stop beating or I should stop breathing (cardiac or respiratory arrest) I HEREBY REQUEST that my attending physician Dr. TUCKER, his associates and assistants, and hospital personnel responsible for my care, DO NOT attempt to restart my heart beat or breathing which is called cardiopulmonary resuscitation (CPR). This means I do not want anyone to compress my chest, insert a tube or other device to force me to breathe, or use electric shock or drugs to force my heart or lungs to start up again after either has stopped.

IN MAKING THIS REQUEST, I ACKNOWLEDGE that my doctor and I have talked about what might happen if CPR is not initiated or carried out. We also talked about CPR procedures in general and the "pros" and "cons" of either initiating or not initiating CPR in my case. My doctor has explained my medical condition to me and gave me an opportunity to ask questions. My questions were answered to my satisfaction.

PATIENT:

I acknowledge that I have read and fully understand the terms of this informed consent for issuance of orders not to resuscitate.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Print Name of Witness

_____
Print Address of Witness

PHYSICIAN:

I have reviewed the above with the Cousin and support the
Patient/Family/Guardian
decision for a Do Not Resuscitate (DNR) order.

_____ E NGUYEN 3/31/00
Signature of Physician Print Name of Physician Date

RELATIVE/GUARDIAN:

(If patient lacks decision-making capacity, complete the following:)

The patient is unable to consent because patient is very-dependent and unresponsive and therefore the above explanations have been made to, and consent has been given and the consent signed by, the patient's legal guardian or closest available relative. A true copy of the Court appointment of guardian, if any, is attached.

_____ Cousin + Health Care Rep. 3-31-00
Signature of Legal Guardian or Closest Available Relative Relationship Date

Kathleen Branch, RN _____
Signature of Witness Print Name of Witness

_____
Print Address of Witness